DOCUMENT RESUME

ED 369 222 EC 302 952

AUTHOR Cox, Gary; Brandt, Vickie
TITLE The Children's Mental Health Integrated Fund: A Preliminary Report.
INSTITUTION Minnesota State Dept. of Human Services, St. Paul.
PUB DATE 13 May 92
NOTE 158p.; For a related document, see EC 302 953. Appendix B contains small print.
PUB TYPE Viewpoints (Opinion/Position Papers, Essays, etc.) (120)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS *Agency Cooperation; Behavior Disorders; Children; Community Programs; Deinstitutionalization (of Disabled); *Delivery Systems; Elementary Secondary Education; *Emotional Disturbances; Financial Support; *Mental Health Programs; Program Administration; *Public Policy; Residential Programs; School Responsibility; *State Programs
IDENTIFIERS *Minnesota

ABSTRACT

This report is a comprehensive description of Minnesota's children's mental health system. It is designed to provide background and guidance to the Children's Integrated Fund Task Force, to assist local coordinating councils, and to serve policymakers outside of mental health who are increasingly asked to consider problems from an interagency perspective. The Children's Integrated Fund Task Force is charged with: devising a funding structure that will move the mental health system toward a community-based, nonresidential system, and with coordinating services across agencies. The existing system is described, including the actors and decision makers, funding sources, expenditures, funding structures and eligibility restrictions, service delivery and availability, and service coordination. Barriers to an effective efficient system are listed, a rationale for system integration is presented, and innovative funding strategies are outlined. The report draws the following conclusions, among others: (1) solving the problems of the children's mental health system will require integration of its uncoordinated components; (2) residential services will continue to be needed, but establishment of a full continuum of community-based services is crucial for earlier intervention; (3) the existing funding structure is sufficiently flexible to create mandated community-based services; and (4) integration of mental health treatment into schools would provide broad treatment access to children and distribute responsibility among agencies. Appendices contain results of a survey of local coordinating councils and information about the missions and responsibilities of state and local level interagency coordinating committees. (JDD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 369 222

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

THE CHILDREN'S MENTAL HEALTH INTEGRATED FUND

A PRELIMINARY REPORT

MAY 13, 1992

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Gary C. Cox
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC 302952

The Minnesota Department of Human Services
wishes to acknowledge:

Gary Cox, Budget Analysis Division
principal analyst and author
project researcher

Vickie Brandt, Mental Health Division
LCC survey designer and appendices author
project researcher
Child and Adolescent Service System Coordinator

Stephen Smothers, Mental Health Division
graphics and layout designer
production coordinator

1st Printing May, 1992
2nd Printing June, 1992
3rd Printing July, 1992
4th Printing September, 1992
5th Printing October, 1992

444 Lafayette Road
Saint Paul, Minnesota 55155
(612) 296-6117
(612) 296-6244 (fax)

BEST COPY AVAILABLE

TABLE OF CONTENTS

		Page
Executive Summary		i
I.	Introduction: Purpose And Perspective Of This Report	1
II.	Guide To The Children's Integrated Fund Task Force	3
III.	The Existing System	5
	The Actors and Decision-makers	5
	Funding Sources	10
	Expenditures	17
	Funding Structure and Eligibility Criteria	30
	Service Delivery and Availability	51
	Service Coordination	64
	Data Sharing and Integration of Information Systems	67
IV.	Barriers To An Effective Efficient System	69
V.	Rationale For System Integration	85
VI.	Innovative Service Models And Funding Strategies	89
VII.	Minnesota's Community-Based Services Demonstration Project	103
VIII.	Conclusions of Research and Analysis	105
Appendix A		i
Appendix B		xvii

EXECUTIVE SUMMARY

I. Introduction And Perspective Of This Report

This report serves four purposes. It is a comprehensive description of the children's mental health system. It will provide background and guidance to the Children's Integrated Fund Task Force, which was established by the 1991 Legislature to study the feasibility of a children's mental health integrated fund. It will assist local coordinating councils which are under mandate to establish protocols for interagency coordination.

Finally, it will serve policymakers outside of mental health who are increasingly asked to consider problems from an interagency perspective, since the issues discussed here are likely to apply outside of mental health.

II. Guide To The Children's Integrated Fund Task Force

State policy regarding children's mental health is clearly moving toward a community-based, non-residential system and increasing resources are being committed to establish necessary services. Policy has additionally embraced the practice of coordinating services across agencies.

The charge of the Children's Integrated Fund Task Force, then, is to devise a funding structure that will make this policy work.

The Task Force should focus on two broad goals: (1) to improve the effectiveness of treatment and the treatment system and (2) to improve the cost efficiency of the system. These goals are compatible. Strategies combining coordinated service delivery with flexible, integrated funding seem to produce healthier clients at a lower cost.

III. The Existing System

The Actors And Decision-Makers

The system includes parts of six state agencies. The Department of Human Services; the Department of Education; the Department of Jobs and Training; the departments of Corrections; Health; and Commerce.

At the local level are county social services agencies; schools; community corrections; public health; juvenile courts and police; and community mental health centers.

Private sector involvement includes community hospitals, private clinics and physicians, health maintenance organizations, insurance companies, self-insured employers, residential treatment facilities, private non-profit agencies, and private foundations.

Planning, advisory, and coordinating groups operate at both state and local levels.

Federal agencies involved are the Department of Health and Human Services, including the Health Care Financing Agency (HCFA) and the Social Security Administration. Also involved is the U.S. Department of Education.

Parents at times can play two opposing roles. Some parents are the de facto case managers for their children's treatment, advocating for appropriate treatment. Parents can also be part of the problem, creating unhealthy environments that contribute to their children's disorders.

The Funding Sources

Funding for children's mental health services comes from many sources.

FUNDS ADMINISTERED BY THE DEPARTMENT OF HUMAN SERVICES

1) **County Social Services Funds** are primarily local property tax dollars, but include state Community Social Services Act (CSSA) dollars and federal Social Services Block Grant (formerly Title XX) dollars. They are the single largest potential source of children's mental health dollars available to local communities. Funding was $37 million in 1990.

2) **Medical Assistance** covers inpatient services, outpatient treatment, day treatment, case management, and professional home-based family treatment. It is the second largest source for DHS mental health programs. Funding was $14 million in 1989, the most recent year for which data are available.

3) **Medical Assistance Regional Treatment Center funds** pay for placements in the two children's RTC programs in Brainerd and Willmar. Expenditures were $4 million in 1990.

4) **Title IV-E Foster Care** reimbursements are used to pay the housing costs for Rule 5 residential treatment and foster care maintenance payments for emotionally disturbed children. Clients must be AFDC eligible. These funds cannot pay for treatment or support services. Expenditures were $3.53 million in 1991.

5) **Children's Community-Based Mental Health Services (Rule 78)** grants fund county costs to establish new CCBMH services which are mandated by the Comprehensive Children's Mental Health Act. Counties must spend 30 percent for case management and the remaining 70 percent for Family Community Support Services (FCSS). Funding was $3.26 million in 1992.

6) **Federal Mental Health Block Grant** (or ADM grant) funded eight county demonstration projects focusing on interagency coordination and community-

based services along with ten projects serving American Indians. Funding was $674,000 for 1991.

7) **Family Preservation Act grants** (formerly Permanency Planning) pay for professional home-based family treatment. Expenditures for 1991 were $.12 million. The fund consists of 72.3 percent direct state appropriations and 27.7 percent federal Title IV-B funds.

8) The **Children's Health Plan** (CHP) began covering outpatient mental health services in July, 1990. It is a state-funded program for children who do not qualify for Medical Assistance. Expenditures were $59,000 in 1990. Passage of the health care reform bill, "Health Right", by the 1992 Legislature will substantially augment the use of CHP for children's mental health services. CHP will be phased out and supplanted by Health Right.

FUNDS ADMINISTERED BY THE DEPARTMENT OF EDUCATION

1) **General Education Revenue (or Foundation Aid)** includes both state and local dollars. It is the basic public education aid and applies to all students. The amount is calculated on a per student basis.

2) **State Aid for Special Education** is specifically for special education expenses and is determined as a fixed percentage of the cost of providing special education.

3) **The Local Levy for Special Education** is property tax funds levied by the school board as a percentage of special education costs.

4) **Federal P.L. 94-142 Flow-through** funds are administered by the U.S. Department of Education and pay for special education expenses of school-aged children.

5) **Federal Early Intervention Funds**, also administered through the U.S. Education Department, come from Part H of P.L. 99-457, the Education of the Handicapped Act Amendments of 1986. It provides dollars for coordinated, multidisciplinary, interagency programs for children from birth to age 3.

FUNDS ADMINISTERED BY THE DEPARTMENT OF JOBS AND TRAINING

The Department of Jobs and Training administers state Minnesota Youth Program and Vocational Rehabilitation appropriations. Federal Title II-B monies of the Job Training Partnership Act are used in conjunction.

JUVENILE CORRECTIONS FUNDS FOR EMOTIONALLY DISTURBED CHILDREN

The Department of Corrections funds some screening, outpatient clinical services, and clinical services for children in correctional institutions. These are state funded.

Precise figures are not available. Data does not distinguish emotionally disturbed clients. An estimate of $847,000 is based on the department's belief that 10 percent of clients in correctional facilities are emotionally disturbed.

Children's Mental Health Expenditures

HUMAN SERVICES EXPENDITURES

Department of Human Services expenditures for children's mental health are estimated at $63.1 million FY in 1991. Residential and in-patient treatment account for 61.1 percent, while 34.5 percent went for non-residential treatment and support services.

The counties are the primary funders of human services programs for children's mental health, paying an average of 45 percent of all human service children's mental health programs. DHS pays 23 percent. The federal government pays 32 percent.

EDUCATION EXPENDITURES

Providing special education to children with emotional/behavioral disturbances (EBD) cost Minnesota a total of $65.2 million during the 1990-91 school year. This includes state, federal, and local funds.

DEPARTMENTS OF JOBS AND TRAINING AND CORRECTIONS EXPENDITURES

The Department of Jobs and Training is estimated to have expended $1.12 million on emotionally handicapped clients in 1991. The Department of Corrections estimated its expenditures at $847,000 in 1991 for emotionally disturbed youth in correctional facilities.

COST-EFFECTIVENESS OF COMMUNITY-BASED SERVICES

Most persons in mental health would agree with the claim that home and community-based services are cheaper than residential treatment or hospitalization. While this may prove correct, there is limited evidence to support it.

A 1989 study of adult mental health by the State Auditor's Office found too little information to judge the relative cost-effectiveness of treatment settings.

Proponents of a community-based model of service delivery base their advocacy on the view that community treatment provides a more effective treatment approach.

Funding Structures and Eligibility Restrictions

The term "funding structure" refers to the pots of money available from various sources, eligibility criteria which determine how those dollars may be spent, and the incentives to provide a service.

An efficient system, in an economic sense, would allow an undisrupted flow of dollars to client services based solely on that client's needs and total dollars available. It is efficient, for example, when a local worker can assess a client's needs, then provide, from a single source of dollars, a package of services which is effective, non-duplicative, and not at cross purposes.

Inefficiency is created when other factors are allowed to determine how dollars are used. These inefficiencies have developed over the years:

1) **Eligibility restrictions** on the various funding sources mean that a service decision-maker must match a client to a funding source which will pay for needed services and, then, to a provider who is both able to provide the service and eligible to receive payment from the funding source. A decision-maker frequently must choose the service for which dollars are available, rather than the service which will most benefit the child.

2) **The fragmented service delivery system**, operating with different goals and separate pots of money, means that all of the dollars in the system are not available to all workers. From each worker's point-of view, many of the funding sources in the system are unavailable.

Because agencies hire staff from particular professional disciplines, e.g. social services agencies hire social workers and schools hire teachers, no single agency which may have access to the emotionally disturbed child commands all the skills necessary to provide needed services.

3) **County fiscal incentives** tend to skew what services are provided to a child. Counties, due to a hodge-podge of state and federal regulations, pay a greater portion of the cost for some services than others. Thus, county decision-makers have an incentive to choose the service that requires the fewest local dollars. The disparity is so great that, in some cases, a very expensive service actually costs the county nothing.

4) **The private health payment system**, like public medical assistance, constrains the care available to clients by way of restrictive criteria in the coverage plan. In fact, many families with private insurance have mental health coverage that is inferior to that available to public assistance clients.

Private insurers usually cover inpatient treatment and, by state law, also cover outpatient therapy. But they tend to disallow payment for ancillary services such as day treatment, home-based treatment, or crisis services. The denial of mental health services tends to be particularly acute with HMOs, some of which claim such services are not "medically necessary". Many private insurance coverage limits are specifically allowed in state law.

5) Use of the Children's Community-Based Mental Health Services grants is **restricted to children with a diagnosis of Severely Emotionally Disturbed (SED)**. Many seriously disturbed children are not classified as SED. There are several reasons. A service provider who both diagnoses an illness and pays for treatment, such as an HMO, may refuse to diagnose an illness that the provider would then be forced to treat. In addition, sometimes therapists and educators resist placing the stigma of a emotional disturbance label on a child. Sometimes children are misdiagnosed.

6) **Inflexible Resources** which cannot be quickly shifted within the system to meet demand can cause inefficiency. If, in a given week, EBD children in a school have an extraordinary need for psychotherapy and

a decreased need for academic instruction, then the set staff ratios create an inflexibility that inhibits efficient delivery of services. However, this inflexibility is inefficient only if demand for that staff occurs in peaks and valleys, creating periods of underutilization.

7) **The funding structure and billing rules** provide a disincentive against case coordination and interagency collaboration because agencies and providers don't get paid for these activities.

8) Minnesota supports a **regional treatment center system** which demands dollars that are not flexible in their use, due to the nature of fixed-costs institutions. As the cost of RTC services climbs, the client population falls, making RTC placements increasingly expensive to counties.

9) **Rates paid for children's mental health services** by Medical Assistance (MA) and General Assistance Medical Care (GAMC) have been so low as to discourage the number and types of providers willing to take emotionally disturbed clients. This should diminish with the passage of the 1992 Health Right law which raises MA reimbursement rates for outpatient and physician services. In addition, vendors who insure public employees, workers' compensation or the Minnesota Comprehensive Health Association will be required to provide services to MA, GAMC, and Health Right clients.

ANALYSIS OF FUNDING SOURCES

An analysis of funding sources showed that services designed to intervene at the earliest stages of an emotional disorder are underfunded relative to services designed to treat a child after a disorder has had a chance to intensify.

Additionally, more money is theoretically eligible within the current funding structure to pay for non-residential and community-based services than for residential services. The fact that funds are not actually spent in these proportions is a result of local treatment and funding choices in response to client need.

Service Delivery And Availability

Minnesota is struggling to resolve a conflict between two distinct service delivery strategies. Common wisdom says the conflict is between residential and community-based services. It is more useful to view it as a struggle over the timing of service delivery: At what stage of an emotional disorder should intervention occur?

The real struggle for the new generation of community-based services is to find resources to intervene at the earliest stage, before a disorder becomes severe. Local professionals and national models indicate that residential and home-based models must both exist. Yet, debate continues over the proper balance.

The basic vision of a service delivery model is not in contention. The Legislature, in 1989, adopted the Comprehensive Children's Mental Health Act that mandates a comprehensive array of services which is coordinated across agencies. The Act

outlines a system of home and community treatment, along with support services necessary to make such non-residential treatment feasible.

Coordination is required at three levels: state agency; local agency; and at the individual case level. The latter duty is given to local case managers.

Despite the mandate to provide the full array of services, counties are not required to fund services beyond the limits of legislative appropriations.

THE SYSTEM IS OVERWHELMED BY SEVERELY DISTURBED CHILDREN

Local workers describe a system besieged by an overwhelming number of children with increasingly severe disturbances. While state policy requires counties to establish services for all emotionally disturbed children, responding to the most severely disturbed children overwhelms most resources, leaving little or nothing for early intervention and the less severely disturbed.

Large numbers of children do not receive mental health services because the disturbances they exhibit do not appear severe enough to command a high priority.

Schools have a greater tendency to recognize behavioral problems than emotional problems because dysfunctional behavior is easier to spot and has a greater impact on the teacher whose classroom may be disrupted. A suicidal child who is not disruptive, for example, probably would not catch many teachers' attention.

Local corrections systems and courts are so backlogged that they ignore disorders that are developing until a child begins to commit serious offenses. Then courts force counties to provide mental health services at far greater potential cost than necessary with early intervention.

The corrections system is a key actor in the overall system that serves emotionally disturbed children. While its role is not specifically to address mental health problems, many children accused of breaking the law are emotionally disturbed. Although much discussion occurs at the local level as to whether a particular child is emotionally disturbed or delinquent, to a significant extent, they are the same children.

Service Coordination

Minnesota's current attempt at a community-based system is disjointed. In order to bring the system's resources to bear on any single client, the disarray must be coordinated.

Local communities have not completed the mandate to establish formal interagency collaboration. However, efforts at interagency coordination of services at the case level is widespread. Most of it is informal, taking the form of interpersonal relationships. It is, however, inconsistent. Some communities have extensive networks involving most service providers; other communities have virtually no coordination.

Integration Of Information Systems

Accurate data on services provided to emotionally disturbed children is difficult to obtain. The local and state agencies which provide services and administer funds vary widely in their abilities to collect information. No interagency data sharing mechanism exists which would provide information on all the services received by an emotionally disturbed child.

The lack of information contributes to fragmentation of funding sources and delivery systems. When a service need is identified but information about current activity is unavailable, the tendency of interest groups and legislators is to create a new program. However, along with the new program comes new bureaucracy and less integration.

IV. Barriers To An Effective Efficient System

Many barriers exist to creation of a children's mental health system which provides therapeutically effective treatment in a fiscally efficient manner. They are identified below.

1) Funding levels are inadequate to establish necessary community-based services without shifting resources away from residential treatment.

2) The funding structure is a barrier to recreating a better system. Eligibility criteria make it difficult to match clients with dollars to pay for the type of services they need.

3) The "least restrictive setting" mandate at times limits treatment options for children who need very intensive intervention immediately. Many counties and courts have interpreted the law to require services to progress step-by-step starting at the least intensive.

4) Mandated coordination procedures can divert resources from local efforts. Many communities operate with effective informal networks. Mandated formal coordination procedures often duplicate existing local initiatives.

5) State agencies' missions are narrowly defined to address separate fragments of a child's total needs.

6) Coordination and advisory bodies set up to address the issue of interagency coordination have not coordinated their own efforts, a number of which are duplicative.

7) The fragmented delivery system limits the resources available to any professional. The narrow scope of his/her agency and professional discipline create inflexibility in service delivery.

8) State family preservation policy promotes family reunification, although local workers believe some families should not be reunited.

9) Schools must address mental health problems with education tools. Education's mandate is to address the emotional problems that stand in the way of a child's educational progress, not to treat clinical disorders. Yet, schools have greater access to children than other agencies; their

services often are the only help a child gets.

10) Seriously ill clients use most of the available resources, leaving little or nothing for prevention and early intervention.

11) Services and qualified children's mental health professionals are in short supply throughout the state.

12) Disorders are not identified early. As severity increases, treatment costs increase.

13) The "conduct disorder" label sometimes has the effect of excluding children from mental health treatment and EBD services and placing them into the corrections system without mental health services.

14) Local actions play a key role in how effectively the system works. The ability of the state to determine how well the system works is limited, particularly with regard to interagency coordination.

V. Rationale For System Integration

The divisions in the system are artificial because they are designed often to respond to mere consequences or symptoms of underlying problems. Emotional disturbance, educational failure, and delinquency seem to have common roots. The forces in children's lives which cause emotional disturbance in one child may just as easily be manifested in a medical malady, anti-social or violent behavior, abuse, or family trauma in another child.

The most serious impediment to coordinating services for a particular child seems to be the inability of any actor in the system to take overall responsibility for the child. The tendency, when progress bogs down, is to hand off the child to another agency or service system.

The Task Force must define what an integrated fund should be. Since emotional disorder, chemical dependency, delinquency, and educational failure result from the same social and personal problems, the most useful fund might be a "children's fund" which would serve all needs of children.

VI. Innovative Funding Strategies

Many states have restructured funding to improve their children's mental health systems. Their objectives have included increasing their resources, cutting costs, and improving services. Strategies being tried throughout the U.S. include:

1) Establishment of multi-agency pools.
2) Restructuring private insurance.
3) Shift of funds from state institutions.
4) Establishment of trust funds as a mechanism for families to contribute money to their children without jeopardizing eligibility for public services.
5) Earmark an independent state fund for children's mental health with its own revenue source.
6) Establish a local children's authority to administer all monies spent on troubled children from the community.
7) Restructure reimbursement to expand revenues and focus resources.

VII. Conclusions Of Research

1) Solving the problems of the children's mental health system will require integration of its uncoordinated components. Integration must take place at the local level.

2) System fragmentation means that the total resources of the system are never available to any single actor. Thus, no one can assume responsibility for a client's overall needs.

3) Residential services will continue to be needed, but establishment of a full continuum of community-based services is crucial for earlier intervention.

4) Responding to the crises of the most severely disturbed children overwhelms most resources, leaving little for early intervention and the less severely disturbed.

5) The existing funding structure is sufficiently flexible to create mandated community-based services. Communities have not shifted dollars from residential services due to continued need.

6) Greater funding is needed. Dollars cannot be shifted from residential and crisis services because abandoning severely disturbed children would create adults who are less healthy, dangerous to society, and more costly in the long run.

7) Integration of mental health treatment into schools would provide broad treatment access to children and distribute responsibility among agencies.

8) Emotionally disturbed and delinquent populations are largely the same children. Maintaining the distinction hinders treatment, allowing one agency to pass the child off to another agency.

9) The private health payment system, like public medical assistance, constrains the mental health care available. Many families with private insurance have mental health coverage that is inferior to that available to public assistance clients.

10) Providing support services to families uses minimal public resources to leverage private resources. A little support can spell the difference between a family that fails and one that succeeds.

11) The lack of good data contributes to the fragmentation of the system. When information about current activity is unavailable, the tendency is to create a new program. The result is new bureaucracy and less integration.

12) The various state and local interagency councils and committees established to coordinate services have failed to coordinate their own efforts.

13) The conclusions of this report are compatible with the directions set in the report of the Governor's Action For Children Commission.

14) The Task Force should consider whether private health insurance should be included in an integrated fund. The 1992 Health Right law creates a new relationship between state government and the private health care industry.

I.

INTRODUCTION

PURPOSE AND PERSPECTIVE OF THIS REPORT

This report must serve four m rs. First, it is a detailed description, o rimer, of Minnesota's children's mental health system; it will serve policymakers, lawmakers, advocates, and anyone else whose work can benefit by knowing how the system works.

Second, it will educate and help set a course for the Children's Integrated Fund Task Force, established by the 1991 Legislature to study the feasibility of integrating the fragmented funding sources which feed children's mental health services.

Third, it will provide guidance to the legislatively-mandated Local Coordinating Councils whose job it is to establish protocols and inter-agency agreements in order to coordinate service delivery across the various local agencies which impact children's mental health clients.

Finally, there is a fourth, unanticipated, audience which this report can serve: state and local policymakers outside of mental health who are increasingly asked to consider their efforts from an interagency perspective. The interagency issues analyzed here in the context of children's mental health will be essentially the same regardless of the population or service delivery system being considered.

In the end, this report is not entirely an objective analysis of the system. While description of the existing system seeks neutrality, the very intent of the legislative request to study funding integration and service coordination places this analysis in a political context: that of the movement toward client-centered service delivery. It is only when the client becomes the focal point of public services that government begins to seek ways to coordinate its agencies' efforts around the client's needs so that clients need not accept whatever service an institution is set up to provide. To some, this may seem the only sensible therapeutic approach, but it is indeed a political perspective.

PROJECT DESCRIPTION

The legislative mandate which initiated the Task Force and this report comes in two parts:

(1) The Laws of Minnesota for 1991, Chapter 292, Article 6, Section 57, Subdivision 1, ordered the Department of Human Services (DHS) to "convene a task force to study the feasibility of establishing an integrated children's mental health fund". The st wide task force must consist of

mental health professionals, county social services staff, providers, advocates, and parents. The children's subcommittee of the State Advisory Council on Mental Health and members of the various Local Coordinating Councils (LCCs) must be represented, along with the commissioners of human services, health, and education plus two state representatives and two state senators.

(2) Subdivision 2 of the same law also ordered each Local Coordinating Council to "establish a task force to develop recommended protocols and procedures that will ensure that the planning, case management, and delivery of services...are coordinated and make the most efficient and cost-effect use of available funding."

Research and analysis was initiated by DHS as a joint effort of the Mental Health and Budget Analysis divisions in order provide the background that would be needed by the Task Force to carry out its mandate. Preliminary findings were summarized in the Mental Health Division's 1992 report to the Legislature and are expanded in this report.

We hope this report will bridge the gap between critiques of the existing system and visions of its future. Research combines (1) a survey of existing literature on children's mental health systems in Minnesota and other innovative states; (2) new research to identify barriers in the system which prevent effective and efficient service delivery, and (3) analysis of the relationships among components of the system.

To analyze relationships across the system we used simulated character studies to gather anecdotal evidence on the system's inner workings. This approach was designed to overcome the lack of hard inter-agency data. The method involves convening a group of mental health professionals, service providers, parents, educators, social workers, planners, corrections and law enforcement officers, and advocates who have direct experience with some aspect of the system. The researcher introduces profiles embodying realistic client characteristics then asks participants to describe their responses to the character. At each point that a decision is made about this child's care, the worker who would make the real-life decision discusses his or her options, limitations, and reasons a particular decision is made. By following a client through the system, the researcher learns how the system works.

Vickie Brandt, Mental Health Division
Gary Cox, Budget Analysis Division

May 1992

II.

GUIDE TO

THE CHILDREN'S INTEGRATED FUND TASK FORCE

The Minnesota Legislature has made it clear that it wants to fashion an effective and efficient system to provide for the mental health of Minnesota's children.

In 1991, lawmakers ordered the Department of Human Services to establish a task f e to determine whether it would be feasibl to integrate funding sources. At the same time, the Legislature sought guidance from the task force on how to coordinate the services which emotionally disturbed children now receive from the existing "non-system" which is, at or demanding and often ineffective.

The Legislature has by no means committed itself to an integrated funding structure: it has only requested a study. But state policy regarding children's mental health is clearly moving toward a community-based, non-residential system and increasing resources are being gathered to establish necessary services. Policy has additionally embraced the practice of coordinating services across agencies.

The charge of the Children's Integrated Fund Task Force, then, is to devise a funding structure that will make this policy work.

The Task Force faces a daunting challenge. Success in the legislative arena demands that the Task Force recommendations not only reflect continuity with recent children's mental health policy but demonstrate both technical and political feasibility. In this, the Task Force will have some help.

This report presents Task Force members with a comprehensive view of the issues they will face over the next several months. In addition, the report analyzes the current children's mental health system with an eye toward identifying the barriers which the system raises in the path of clients and conscientious professionals. Further, the report analyzes financing and service delivery models being tested in this and other states, providing the Task Force with options from which to synthesize a funding structure appropriate to Minnesota's political and administrative environment.

The Task Force should focus on two broad goals: (1) to improve the effectiveness of treatment and the treatment system and (2) to improve the cost efficiency of the system. Research done in preparation for this report indicates that these goals are compatible. Strategies which combine coordinated service delivery with flexible, integrated

funding seem to produce healthier clients at a lower cost.

While the Legislature has focused new attention and resources on children's mental health services in recent years, new dollars have been insufficient to fully implement the 1989 Comprehensive Children's Mental Health Act, Minnesota's manifestation of the community-based model. Although professionals throughout the children's mental health system maintain that an infusion of resources will be required to serve the needs of the state's emotionally disturbed children, the Task Force should recognize that these programs must compete for dollars against other valid needs of the state's population. Creation of a more effective and efficient system would help to smooth the way for new monies.

III.

THE EXISTING SYSTEM

The Actors and Decision-Makers

The complexity of the children's mental health system can be discerned from the wide range of players, both agency and individual, involved.

STATE AGENCIES

The system includes parts of six state agencies. The Department of Human Services (DHS) is most commonly associated with mental health, but it is nearly matched by the Department of Education in dollars spent, numbers of staff committed, and resources committed to innovations for children's mental health.

The **Department of Human Services** administers the system directly with its Mental Health, Residential Program Management, Health Care Programs, Children's Services, and Licensing divisions. Several other divisions impact programs and clients. The Mental Health Division focuses on community and out-patient treatment while the Residential Program Management Division manages the state's Regional Treatment Center children's programs at Brainerd and Willmar. In 1992, The Mental Health Division established a distinct children's mental health section to implement the Children's Mental Health Act.

The **Department of Education** supervises special education programs in the 423 school districts in the state including those programs for emotionally disturbed children. By state and federal law, school districts must serve children from birth to age 21. In addition to specialized instruction provided by schools, the department funds a range of related psychological, diagnostic, and social work services and interventions; the breadth of these services in each school is largely dependent on local policy and resources.

The **Department of Corrections** often works with emotionally disturbed children who have failed in other parts of the system. The department estimates that 10 percent of juvenile residents at the Red Wing and Sauk Centre facilities are emotionally disturbed. Corrections administers psychological and psychiatric evaluations and makes referrals to clinical programs, which are funded through social services.

The **Department of Health** trains personnel who administer the Early and Periodic Screening, Diagnosis, and Treatment

(EPSDT), which screens children for emotional and medical problems. Training also is provided for local public health nurses who work with families in their homes and assess interactions between parents and children to promote early intervention. The department also provides for case management, advocacy, and the psychosocial needs of special needs children in the Services for Children with Handicaps (SCH) clinics.

The **Department of Jobs and Training** administers federal and state funds for adolescent employment and job training programs; more than a quarter of whose clients are physically, emotionally, or mentally handicapped. DJT regional staff also serve on mandated "transition teams" which help older adolescents shift from child to adult programs and services.

The **Department of Commerce** regulates private insurers who pay for mental health services. This includes profit-making insurance companies and non-profit insurers such as Blue Cross-Blue Shield. It does not include Health Maintenance Organizations (HMOs) which are regulated by the Department of Health.

LOCAL ACTORS

Most local programs for emotionally disturbed children are supervised by a corresponding state agency. Yet, the salient feature of the state-local relationship is the degree of independence that local professionals feel from their state supervisors. It is not as though state agencies are viewed as irrelevant; in fact, many local professionals wish the state would take a stronger leadership role. However, in the eyes of the local worker it is they, not the state, who are ultimately responsible for the client. The state's purpose, then, would be to help the locals to do their jobs.

County social services agencies impact the system at many points. Child social services and protection workers provide family-based services, evaluate family conditions, make decisions on out-of-home placements, and provide case management. Some counties have mental health units that provide direct therapeutic services. Emotionally disturbed children are served by diverse staffs of social workers, mental health professionals and paraprofessionals, financial workers, case managers, program planners, and a variety of social service paraprofessionals.

Public health departments conduct early childhood health screenings, which include evaluation of mental illness, and often are involved with families with emotionally disturbed children. Their staffs include public health nurses and paraprofessional health care personnel.

Community corrections agencies provide probation services to delinquent children, many of whom are emotionally disturbed. They work with schools regarding truancy cases; they team with child protection units in many counties; and they work closely with law enforcement and county prosecutors. Probation officers work for the

courts. Some function primarily as law enforcement officers, while other function much as a social worker.

Juvenile Courts frequently order mental health services for children who have become involved with the law. Since the corrections system has few services or facilities designed to assess or treat emotional disturbance, judges usually order county social services agencies to pay for services available in their systems. Additionally, juvenile courts impact schools by way of their involvement with truancy issues and dispositions that order children to attend school.

Police juvenile officers, in addition to traditional law enforcement duties, frequently are involved in crime prevention and diversion activities. They work closely with probation officers and, frequently, with schools, child protection staff, and community youth organizations.

Schools serve more emotionally disturbed children than the other systems; schools must provide for emotionally disturbed children on an all-day basis for many years. They must evaluate emotional and behavioral problems and provide specialized instruction on five different levels of intensity. Emotionally disturbed children receive services from special education teachers, school social workers, and counselors as well as regular classroom teachers.

Community mental health centers, funded by a county or multiple counties, are direct mental health service providers and provide a wide array of non-residential mental health services, usually under some contractual arrangement with supporting counties. Their staffs include psychiatrists, psychologists, and other licensed mental health professionals.

Private sector involvement includes community hospitals, private clinics and physicians, health maintenance organizations, insurance companies, self-insured employers, and a few residential treatment facilities (Rule 5 licensed). Private non-profit agencies serve variously as direct treatment providers as well as advocates. Private foundations, such as the Robert Wood Johnson Foundation, develop innovative systems models and fund demonstration projects. Also included are community organizations such as the YMCA and churches.

FEDERAL AGENCIES

Federal agencies administer sources of funding and their eligibility criteria are tremendous forces in shaping the structure and flexibility of the system. They also administer or enforce laws regarding disabled children, public assistance, health standards, and out-of-home placements. The Department of Health and Human Services includes the Health Care Financing Agency (HCFA), which administers Medicaid. The Social Security Administration administers supplemental security income. Also involved is the U.S. Department of Education.

OTHER ACTORS

Planning, advisory, and coordinating groups operate in Minnesota at both the state and local levels. Most were created by legislative or executive mandate, but private, nonprofit advocacy groups exist. Some play an advocacy role, evaluating the system from a consumer point-of-view and recommending policy changes. Other groups are concerned primarily with service coordination. Some advise the Legislature or other governing bodies on mental health policy. At the national level, such organizations as National Institute for Mental Health advise state planners and participate in the development of innovative service delivery and funding models.

Parents play two opposing roles in the system. Some parents are the de facto case managers for their children's treatment. They seek -- sometimes beg for -- services for their children. They provide second opinions on their children's assessments and advocate for appropriate treatment. Efforts to support these parents occupy the efforts of many professionals in the system.

Parents can also be part of the problem, creating unhealthy or dangerous environments that cause or contribute to their children's illnesses. In these cases professional response can vary from helping the parents find more appropriate ways to cope with the child to removing the child from the home.

Parents who seek out services for their children face several obstacles, our case studies showed. Parents, at least at first, are unfamiliar with the system and face great difficulty tracking down the services their children need. Another obstacle is being labeled as a parent who is looking for problems. "Somehow, you're a parent who just loves going to counselors," one mother said. "You're over-protective."

Sometimes, parents get pinched between the competing philosophies in the system. A mother participating in our case studies once made an emergency telephone call to the county for help with a violent son, but she called the wrong department:

"I called Child Protection because I was literally sitting on top of him. He had pulled knives, at age nine, and was threatening to kill us. My phone call was to see what I could do to get some protection from a nine-year-old. I was told by the county that for him to be violent and out of control, there was something going on in our family; there has to be some abuse. So they opened their file and we were investigated. There wasn't anything, but we were treated automatically like we had done something to this kid. That was very, very hurtful and shocking and painful."

A child protection worker listening to the mother's story told her: "Had you called a mental health provider or talked initially just to a therapist, you might never have gotten into the child protection system."

In contrast to the parents who have worked against great odds to obtain services for their children, an EBD teacher spoke of families who create unhealthy environments for their children. Children tell her stories of abuse at home in desperate efforts to get away from their families:

"They know I'm a mandated reporter," she said. "They share things with me so they can get removed from the home. Maybe they're removed for a day or overnight. The next time, for maybe five days, then it's two weeks. They up the ante until some of the stories you hear are just god-forsaken. I don't know that they're true or not. But the child knows they've got to make it more serious to get what they want and need."

Local workers participating in our studies expressed frustration that the system spends too much money on families who have little chance of becoming healthy. Nothing remains for families who could be helped.

"You see lots of money going into trying to correct families that, at least in my own personal opinion, are not correctable," the EBD teacher said. "And you see it happening ten times. The child will be removed, put back. You pay for foster care, for all these different things. It's just a vicious cycle. Then you see wonderful, nurturing families who maybe need just one shot from the system and they can't get it because all the money is tied up with these people who are spiraling."

Funding Sources

Funding for children's mental health services comes from many sources. The two largest sources in Minnesota are those administered by the Department of Education and the Department of Human Services.

FUNDS ADMINISTERED BY THE DEPARTMENT OF EDUCATION

1) **General Education Revenue (or Foundation Aid)** is both state and local dollars, including local excess levy referenda, and is the basic public education aid. It applies to all students. The amount is determined by a formula which is calculated on a per student basis; i.e. the more students in the school district, the more money the district receives. The portion of this fund provided by the state depends on the wealth of the district. The amount allocated for EBD children in 1990-91 -- $15.4 million -- is based on those children receiving EBD services halftime or more.

The aid formula is as follows:

Early Childhood Special Education:
$3050 x .5 per-pupil unit = $1525

Elementary age student:
$3050 x 1.0 per-pupil unit = $3050

Secondary age student:
$3050 x 1.30 per-pupil unit = $4117.50

2) **State Aid for Special Education**, provided by the Legislature, is specifically for special education expenses and is determine as a fixed percentage of the cost of providing special education. For the 1990-91 school year, $24.8 million was allocated.

Reimbursement for personnel is comprised of state aid and local levy dollars and is determined by a salary-based formula. A fixed percentage of aid is paid on contracted personnel, supplies and equipment, and travel for early childhood home-based services. Contracted services for students and residential placements receive a percentage of aid based on the difference between the cost of the program and General Education Revenue received. The aid formulas for 1991-92 are as follows:

Salaries
The formula provides 56.4 percent of salaries for regular school district employees, not to exceed $15,700 in aid per employee. Full-time employees with salaries in excess of $27,836 are subject to the this salary aid cap. Part-time salary aid is prorated accordingly. Districts may levy for the difference between the salary cap and 66 percent of the salary.

For 1992-93, legislation authorizes aid on salaries at 55.2 percent with the cap at $15,320. The cap affects salaries above $27,753.

Personnel Contracts
The state pays 52 percent for contracted personnel, i.e. persons who are not regular employees of the district.

Instructional Supplies and Equipment
The formula provides 47 percent of the cost of instructional supplies, materials, and equipment, not to exceed an average of $47 of aid per handicapped child as determined by a duplicated child count.

Contracted Student Services
The state pays 52 percent of this expenditure after general education revenue has been subtracted.

Early Childhood Home Based Staff Travel
The formula pays 50 percent of travel expenses for early childhood home based services personnel.

Education in Residential Placements
The formula pays 57 percent, minus general education revenue, for educating students in residential placements. To students for whom no district of residence can be determined, the formula provides 100 percent of placement costs after subtracting general education revenue.

3) **The Local Levy for Special Education** consists of local property tax funds, levied by the local school board as a percentage of special education costs. For 1990-91, $22.6 million was allocated.

4) **Federal P.L. 94-142 Flow-through** funds are administered by the U.S. Department of Education and pay for special education expenses of school-aged children.

The feds pay 100 percent of the costs of the programs they fund. Indirect costs may be included, if requested. For 1990-91, $1.45 million was allocated.

5) **Federal Early Intervention Funds**, also administered through the U.S. education department, come from Title I (or Part H) of P.L. 99-457, the Education of the Handicapped Act Amendments of 1986. It provides dollars for coordinated, multidisciplinary, interagency programs for children from birth to age 3.

6) **Capital/Equipment Aid Funds** pay for building and materials cost which are apportioned to EBD students. For 1990-91, about $.9 million was allocated.

FUNDS ADMINISTERED BY THE DEPARTMENT OF HUMAN SERVICES

1) **County Social Services Funds** are primarily local property tax dollars, but include state Community Social Services Act (CSSA) dollars and federal Social Services Block Grant (formerly Title XX) dollars in the relative shares shown below:

Local tax dollars	74 percent
State CSSA grant	14 percent
Federal Title XX	12 percent

They are the single largest potential source of children's mental health dollars available to local communities. According to counties' 1992 mental health plans, they intended to spend about $50 million of these funds for children's mental health services. That is approximately 10 percent of total county social service funds.

The state and local block grant funds are the most flexible of the non-local dollars available to counties and may be spent on

any service for any client to pay any provider that is stipulated by county policy. They are spent whenever other funds are inadequate to meet mandates and to meet local priorities.

2) **Medical Assistance** covers inpatient services, outpatient treatment, day treatment, and case management. Starting January 1, 1992, MA also pays for professional home-based family treatment.

MA paid approximately $14 million for children's mental health services in 1989. These services are subject to a 54.43 percent federal reimbursement. Since 1991, there has been no county share for MA except for Regional Treatment Center expenditures for which counties pay 22.8 percent or half of the non-federal share.

MA is second largest source of children's mental health funding. Traditionally restricted to medical types of services, it has been used to pay for high-cost hospitalization and residential treatment. But MA use has been expanding to non-residential services. MA now pays for case management, a crucial function for a community-based system because it coordinates a variety of services from various providers around the particular needs of a client.

Starting in 1992, MA pays for professional home-based family treatment, i.e. it will send mental health professionals to the home to provide therapy that was once available only in clinics and hospitals. MA has always paid for outpatient treatment, another crucial component of a community-based system. Its use has been limited by the lack of support services that make outpatient treatment feasible. MA cannot pay for support services.

While MA eligibility criteria make it theoretically available to pay for many children's mental health services, providers complain that cumbersome record-keeping and billing procedures discourage many providers who could otherwise use it. Schools, for example, have generally ignored MA as a source of funding for children's mental health services.

3) **Family Preservation Act Grants** (formerly Permanency Planning) pay for professional home-based family treatment. The grant for 1992 is $4.7 million. The fund consists of 72.3 percent direct state appropriations and 27.7 percent federal Title IV-B funds.

Counties spent only about 3 percent of the Family Preservation grant for professional home-based family treatment in 1991 -- approximately $116,000. The remainder of the grant paid for child welfare or child protection services. The grants fund a broader category of six services known as "Family-Based Services", focused primarily on preventing out-of-home placements and reuniting children who have been placed.

The family preservation fund includes three additional grants. Not included in the figure listed here are a one-half million dollar special incentive grant from the 1991 Legislature; it may be used to pay for home-based treatment. Also not included are a one-million dollar Families First grant and a $460,000 minority grant, neither of which may fund children's mental health services.

4) **Medical Assistance Regional Treatment Center funds** pay for placements in the two children's RTC programs in Brainerd and Willmar. Expenditures were $4 million in 1990.

Dedicated state RTC appropriations are used primarily as operating capital until other funds are collected.

5) **Title IV-E Foster Care** reimbursements are used to pay the h ng costs for Rule 5 residential treatment and foster care maintenance payments for emotionally disturbed children. Clients must be AFDC eligible. These funds cannot pay for treatment or support services.

Title IV-E reimbursed approximately 54 percent, or $3.53 million, of substitute care costs for emotionally disturbed children who were IV-E eligible in 1991. About 38 percent of children in substitute care are IV-E eligible.

6) **Children's Community-Based Mental Health Services (Rule 78)** grants fund county costs to establish new CCBMH services which are mandated by the Comprehensive Children's Mental Health Act. Support services are those which make it feasible to treat a child while living in his or her own home.

Grant rules require counties to spend 30 percent of these dollars for case management which counties must have made available by April 1, 1992. The remaining 70 percent is for Family Community Support Services (FCSS), but rules allow expenditures under this category for day treatment, home-based treatment, and therapeutic support for foster care. Outpatient Treatment, a crucial component of a community-based system, cannot use FCSS grants. Residential and RTC treatment also are excluded.

The 1990 Legislature began CCBMHS with an annualized appropriation of $1.2 million. The 1991 Legislature increased this grant to an annualized level of $3.36 million through June 30, 1993. Funds are for non-MA-eligible clients or non-MA-eligible services for MA clients.

7) The **Children's Health Plan** (CHP) began covering outpatient mental health services in July, 1990. It is a totally state-funded program for children who do not qualify for Medical Assistance and whose parents do not exceed income criteria. Outpatient mental health services carry a ceiling of $1,000 per 12-month period. Children's Health Plan expenditures for mental health service for CY 1990 were $58,900.

Passage of the health care reform bill, "Health Right", by the 1992 Legislature will substantially augment the use of the Children's Health Plan for children's mental health services. CHP will be phased out and supplanted by Health Right.

The ceiling on outpatient treatment is raised to $2,500 annually per child and medication management is exempt from the ceiling.

Service coverage is expanded to include inpatient hospital treatment starting July 1, 1993.

Eligibility is expanded to cover children who are at least one year old but less than 18 years old whose gross family incomes are equal to or less than 185 percent of the federal poverty guideline and who are not eligible for Medical Assistance or privately insured.

On October 1, 1992, families and dependent siblings of CHP-eligible children will become eligible for Health Right. Enrollees will continue to be eligible even if their incomes later exceed the limit. Then, on January 1, 1993, all children, parents, and dependent siblings residing in the same household who are not eligible for Medical Assistance will become eligible for Health Right.

Individuals, once enrolled, will continue to be eligible for Health Right regardless of age, place of residence, or presence of children in the household.

Enrollees will begin paying premiums for Health Right coverage based on a sliding fee scale starting October 1, 1992.

8) **Federal Mental Health Block Grant** (or ADM grant) funds are targeted to underserved populations. They funded eight county demonstration projects focusing on interagency coordination and community-based services along with ten projects serving American Indians. Funding was $674,000 for 1991.

9) **Supplemental Security Income** (SSI) / **Mn Supplemental Aid** (MSA) do not pay for mental health treatment but provide monthly payments to low-income children who are disabled, defined as "any medically determinable physical or mental impairment.

SSI is federal money established as Title XVI of the Social Security Act. Recipients receive cash payments from the federal government. MSA is a mandatory state supplement of SSI and recipients receive payments from the state. Both are entitlement programs available to any individual who meets the income, asset and disability criteria.

10) **Non-Service Funds**: Other funds which are not used to pay for services have been made available to support the children's mental health system. The state received $261,000 Child and Adolescent Services System (CASSP) grant for 1990 and 1991 from the National Institute for Mental Health. These funds are focused on developing strategies of interagency collaboration and service coordination at both state and local levels and, thus, have assisted the demonstration projects funded by the Mental Health Block Grant. Participation also ties Minnesota into a nationwide network of states developing innovative approaches to service delivery and funding.

Figure 1 shows the relative contributions from DHS funds for children's mental health services. Data is from different years so expenditures are not exact.

FUNDS ADMINISTERED BY THE DEPARTMENT OF JOBS AND TRAINING

The Department of Jobs and Training administers state appropriations for the

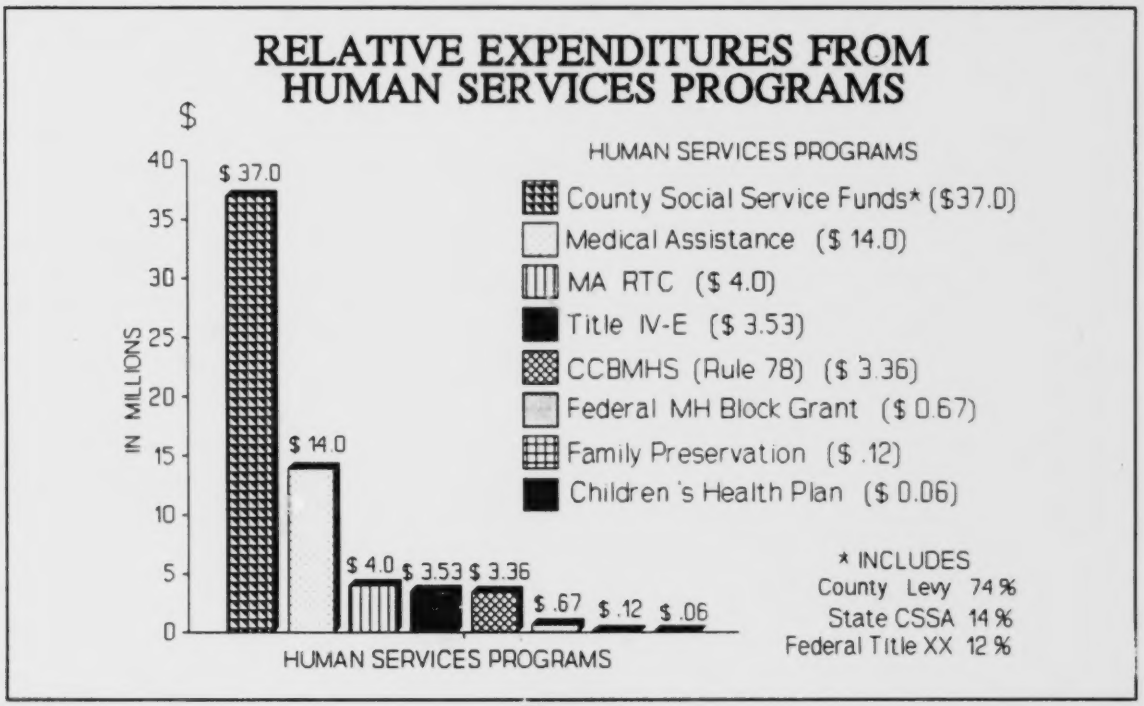


Figure 1

Minnesota Youth Program, targeted at adolescents at risk of dropping out of school. It also funnels federal monies from Title II-B of the Job Training Partnership Act to the same population.

A Vocational Rehabilitation Program uses 80 percent federal and 20 percent state monies to help handicapped people maintain jobs. Most of its clients are adults but emotionally handicapped adolescents also are served. An Extended Employment Program uses all state funds to serve a few emotionally disturbed children with their transition into adult employment.

JUVENILE CORRECTIONS FUNDS FOR EMOTIONALLY DISTURBED CHILDREN

The Department of Corrections funds some screening, outpatient clinical services, and clinical services for children in correctional placement. These services are funded by the state Legislature.

However, the precise amount of that funding is not available since the department's data does not distinguish clients with emotional disturbance. A funding estimate of $847,000 is based on the department's estimate that 10 percent of its clients in the Red Wing and

Sauk Centre correctional facilities are emotionally disturbed.

The expenditure estimate is based on the cost of care for the 10% of correctional facility residents in special education categories. Additionally, the figure includes dollars spent on psychological and psychiatric services contracts.

MISCELLANEOUS SOURCES

The Comprehensive Children's Mental Health Act (M.S. 245.481) requires parents to pay for community-based services and case management on a sliding fee basis.

Courts sometimes require that families of a juvenile delinquent pay court costs relating to their cases.

Expenditures

Education and human services expenditures represent the vast majority of public support for emotionally disturbed children. The total, including federal, state, and local dollars, is approximately $269 million over two years. Figure 2 compares expenditures by department and private insurance.

Department of Education is the largest contributor to services for emotionally disturbed children, paying for special instruction and related services. The Department of Human Services is a close second, paying for mental health treatment, support services, case management, and housing. The Department of Jobs and Training assists emotionally handicapped children make the transition into the job market. The Department of Corrections expends dollars on assessment and therapy for children in state correctional facilities.

EDUCATION EXPENDITURES

Providing special education to emotional behavioral disturbed (EBD) children in Minnesota cost a total of $65.2 million during the 1990-91 school year. This figure includes state, federal, and local funds.

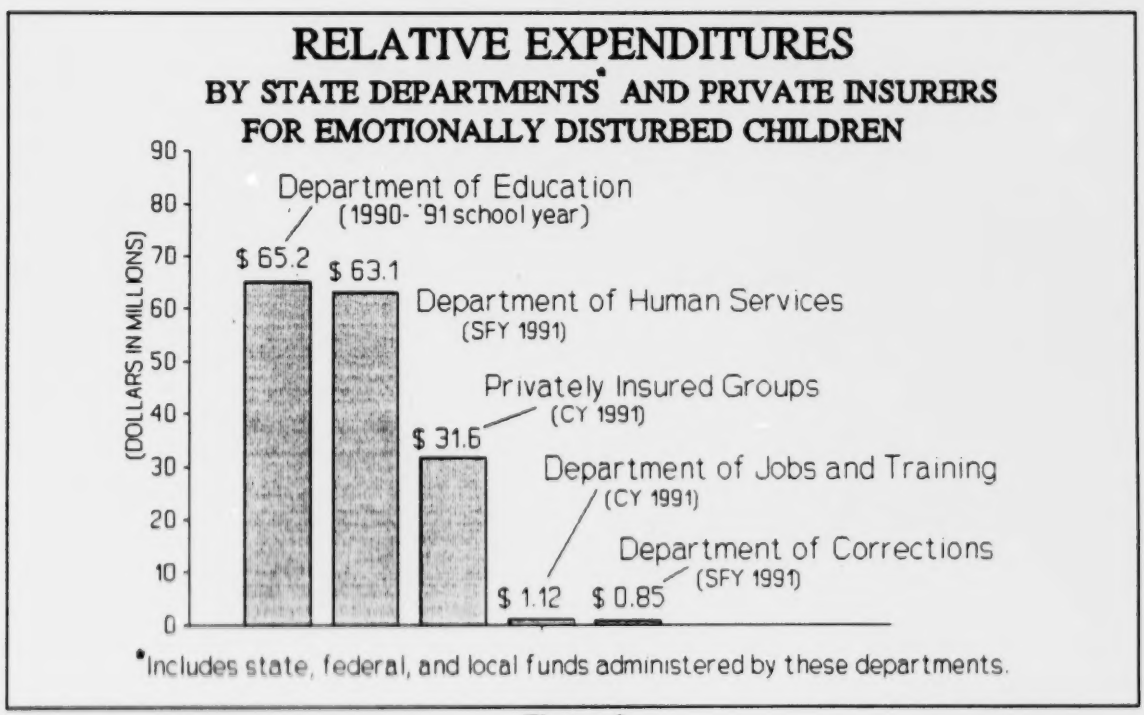


Figure 2

EMOTIONAL BEHAVIORAL DISORDER

TOTAL LOCAL, STATE, AND FEDERAL SPECIAL EDUCATION EXPENDITURES

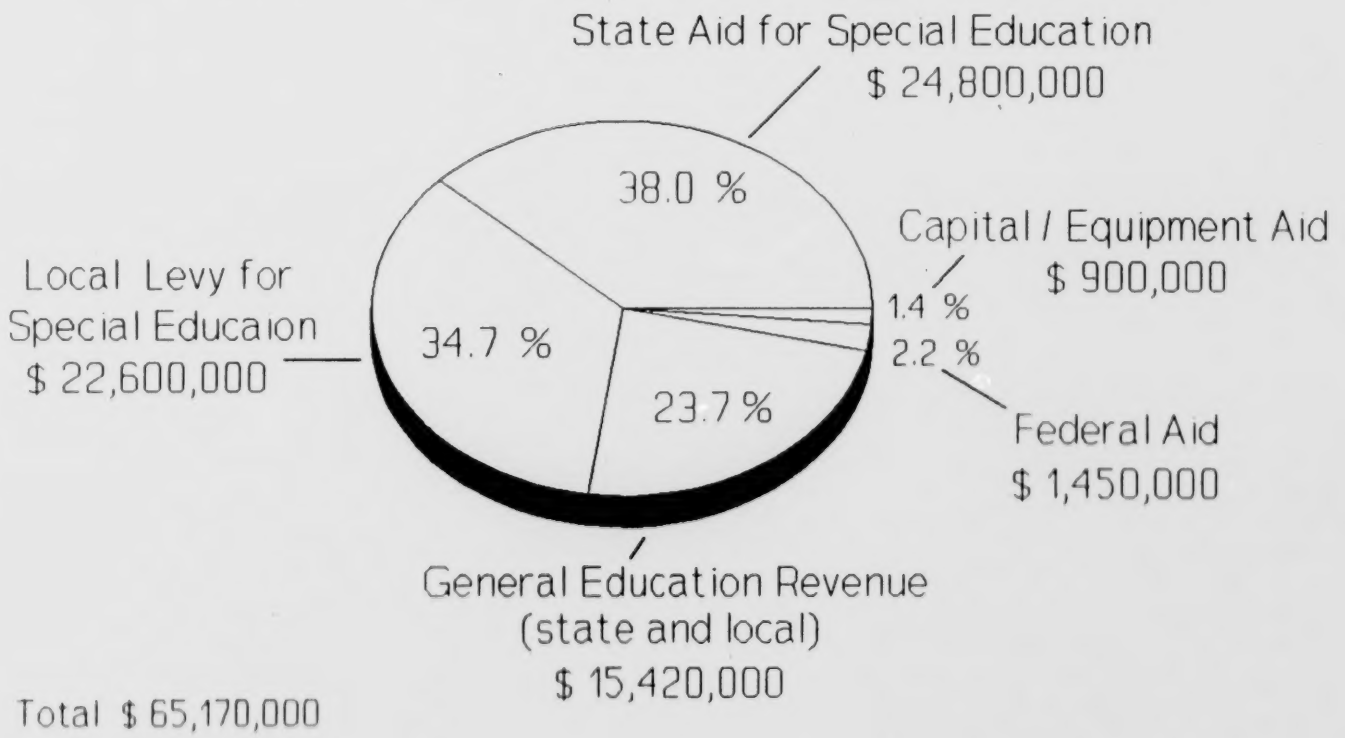


Figure 3

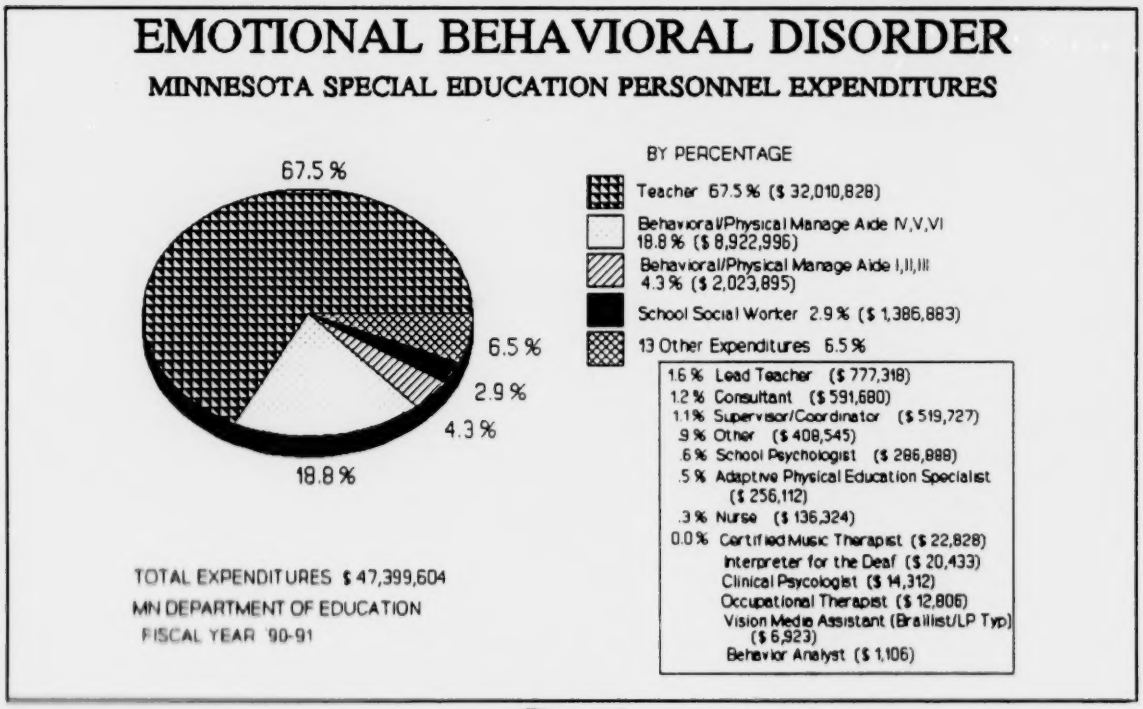

EMOTIONAL BEHAVIORAL DISORDER
MINNESOTA SPECIAL EDUCATION PERSONNEL EXPENDITURES
67.5 %
6.5 %
2.9 %
4.3 %
18.8 %
TOTAL EXPENDITURES $ 47,399,604
MN DEPARTMENT OF EDUCATION
FISCAL YEAR '90-91
BY PERCENTAGE
Teacher 67.5 % ($ 32,010,828)
Behavioral/Physical Manage Aide IV,V,VI 18.8 % ($ 8,922,996)
Behavioral/Physical Manage Aide I,II,III 4.3 % ($ 2,023,895)
School Social Worker 2.9 % ($ 1,386,883)
13 Other Expenditures 6.5 %
1.6 % Lead Teacher ($ 777,318)
1.2 % Consultant ($ 591,680)
1.1 % Supervisor/Coordinator ($ 519,727)
.9 % Other ($ 408,545)
.6 % School Psychologist ($ 286,888)
.5 % Adaptive Physical Education Specialist ($ 256,112)
.3 % Nurse ($ 136,324)
0.0 % Certified Music Therapist ($ 22,828)
Interpreter for the Deaf ($ 20,433)
Clinical Psycologist ($ 14,312)
Occupational Therapist ($ 12,806)
Vision Medio Assistant (Braillist/LP Typ) ($ 6,923)
Behavior Analyst ($ 1,106)

Figure 4

The largest share of the EBD expenditure figure is $24.8 million in state special education aid to local districts. Almost equal, is the local school levy expenditure for EBD of $22.6 million. The federal contribution is $1.45 million, just over 2 percent.

More than $15.4 million is spent in combined state/local general education revenues. Expenditure data in this category follows only those EBD students who receive special education services halftime or more.

An additional estimated $.9 million per year is expended on EBD children for capital expenses and equipment.

Spread over an unduplicated student count of 12,961 (1990-91), the cost is just over $5,028 per EBD student annually.

Figure 3 shows a breakdown of the total education expenditures for EBD children.

Figure 4 shows state special education personnel expenditures.

Figure 5 shows the federal expenditures for special education personnel.

Related Services For Special Education

Current expenditure data is not available at this time for related services for EBD children. Related services means transportation and such developmental,

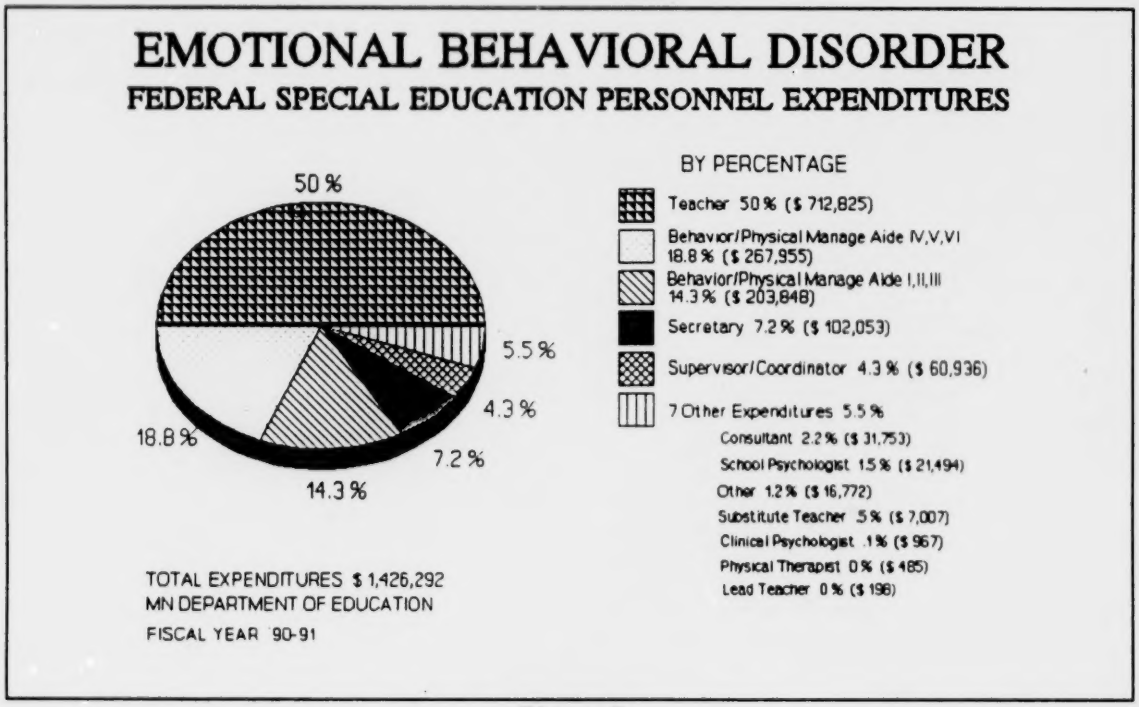

EMOTIONAL BEHAVIORAL DISORDER
FEDERAL SPECIAL EDUCATION PERSONNEL EXPENDITURES
BY PERCENTAGE
50 %
5.5 %
4.3 %
18.8 %
7.2 %
14.3 %
Teacher 50 % ($ 712,825)
Behavior/Physical Manage Aide IV,V,VI 18.8 % ($ 267,955)
Behavior/Physical Manage Aide I,II,III 14.3 % ($ 203,848)
Secretary 7.2 % ($ 102,053)
Supervisor/Coordinator 4.3 % ($ 60,936)
7 Other Expenditures 5.5 %
Consultant 2.2 % ($ 31,753)
School Psychologist 1.5 % ($ 21,494)
Other 1.2 % ($ 16,772)
Substitute Teacher .5 % ($ 7,007)
Clinical Psychologist .1 % ($ 967)
Physical Therapist 0 % ($ 485)
Lead Teacher 0 % ($ 196)
TOTAL EXPENDITURES $ 1,426,292
MN DEPARTMENT OF EDUCATION
FISCAL YEAR '90-91

Figure 5

corrective, and other supportive services as are required to assist the handicapped child benefit from special education.

Related services include: speech pathology and audiology; psychological services; physical and occupational therapy; recreation; early identification and assessment; counseling; and medical services for diagnostic or evaluation purposes. The term also includes school health services and social work services as well as parent counseling and training.

To use these funds, the individualized educational plan (IEP) team must conclude that the primary instructional services are insufficient for the child/youth to meet his/her instructional goals and objectives.

It is not clear who is liable for the cost of related services. Although the federal law says that schools must ensure that eligible children receive related services, it was not the intent of Congress that schools alone should fund these services.

It also is unclear which agency is supposed to take the lead role. Schools must work cooperatively with other child serving agencies and mental health providers to utilize available resources. State government has not determined how this education mandate relates to the human services mandate contained in the Children's Comprehensive Mental Health Act to

provide an array of mental health services to children.

HUMAN SERVICES EXPENDITURES

The county is the primary funder of human services for children's mental health, paying an average of 45 percent across all human services children's mental health programs. The federal government pays about 32 percent.

DHS pays 23 percent of children's mental health costs. By contrast, DHS funds pay 57 percent of mental health costs for adults, according to the 1991 Mental Health Report to the Legislature.

The child-adult total expenditures are:

1991 estimated DHS expenditures
total adult $227.5 Million
total child $63.1 Million

When looking at Department of Human Services estimated expenditures for children's mental health, the $63.1 million estimated for FY 1991 shows that residential and in-patient treatment account for 61.1 percent, while 34.5 percent went for non-residential treatment and support services.

Residential treatment can be further broken down by 1991 estimates: In-patient treatment in RTCs and acute care hospitals is 23.8 percent. Community residential treatment including Rule 5 residential facilities and therapeutic support for foster care is substantially larger at 37.3 percent.

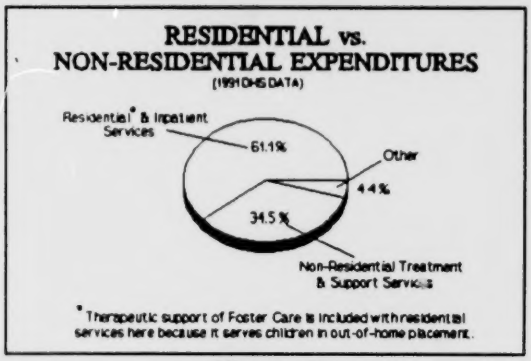


Figure 6

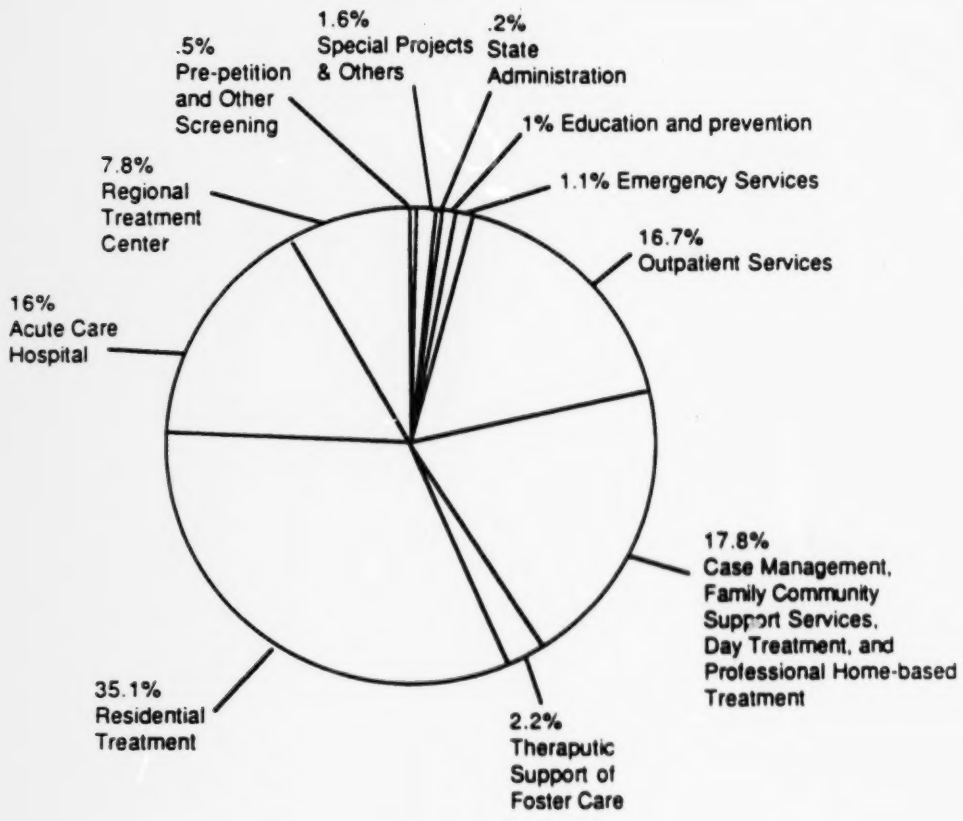
Non-residential services also can be further broken down: Combined expenditures for case management, family community support services, day treatment, and professional home-based family treatment are 17.8 percent. Outpatient treatment is 16.7 percent.

About 4 percent of DHS-administered dollars are spent for assessment and prevention-type services. State administration accounts for only .2 percent.

Figure 7 shows 1991 Department of Human Service Expenditures for primary children's mental health services, plus RTC and state administration expenditures.

Figure 8 can be used to track relative DHS expenditures over a period of time. The data do not include Medical Assistance payments, so the total expenditures shown for each year are lower than actual expenditures. In addition, the numbers are projections derived from county mental health plans which, historically, have varied from actual expenditures.

FISCAL 1991
Estimated DHS Expenditures
Children's Mental Health Services



TOTAL: $63,100,000

In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus private insurance and private pay.

This table does not include Income Maintenance payments for living expenses.

Figure 7

COUNTY PLANNED EXPENDITURES FOR CHILDREN'S MENTAL HEALTH SERVICES

SERVICES (Dollars in millions)	EXPEND. APPROVED '90	EXPEND. APPROVED '91	EXPEND. PROPOSED '92	EXPEND. PROPOSED '93
CASE MANAGEMENT[1]	3.92	5.03	3.34	3.50
FCSS[1]	1.56	2.22	1.19	1.44
DAY TREATMENT[2]	3.63	4.04	6.26	6.31
PROF. HOME-BASED TREATMENT[1]	2.34	2.64	2.15	2.22
THERAPEUTIC SUPPORT[1]	1.39	1.74	1.06	1.09
OUTPATIENT TREATMENT[1]	5.83	6.02	4.70	4.74
RULE 5[3]	22.21	22.25	24.00	23.93
RTC[4]	0.21	0.22	0.55	0.58
ACUTE CARE HOSPITAL[3]	0.34	0.37	0.46	0.45
EII[5]	0.22	0.27	1.41	1.44
EDUCATION/PREVENTION[6]	0.37	0.47	0.30	0.30
24HR. EMERGENCY[1]	0.70	0.86	0.55	0.56
	42.07	46.13	45.97	46.56

[1]Peaked in 1991; then will drop below '90 level; expected to grow.
[2]Growing each year.
[3]Still growing; expected to peak in 1992.
[4]Expected to double from 1991 to 1992.
[5]Growing each year; expected to jump 5 times from '91 to '92.
[6]Peaked in 1991; then will drop below '90 level and hold steady.

Data do not include Medical Assistance Expenditures.
Expenditure data are projections from county mental health plans.

Figure 8

DEPARTMENT OF JOBS AND TRAINING EXPENDITURES

The Department of Jobs and Training administers two distinct classes of programs which serve emotionally disturbed adolescents.

The Community-Based Services Division administers the Youth Employment and Training Programs which serve 14 to 21 year olds who are economically disadvantaged. Priority is given to those at risk of dropping out of school. Services include work experience, remedial education, basic skills training, personal counseling, vocational counseling, mentoring, peer support groups, drug awareness training, and tutoring.

Emotionally handicapped adolescents make up only a small portion of the program's clients. Children with mental and physical handicaps are far more numerous, as are children who are not handicapped.

The youth employment programs consist of two components. First, the state-funded Minnesota Youth Program runs year-around. In 1991, it spent $195,000 serving 244 emotionally handicapped children, which made up 7.4 percent of program clients.

Second, the Summer Youth Employment and Training Program is federally funded under Title II-B of the Job Training Partnership Act. It runs, as its name implies, only in the summer. In 1991, it spent $451,000 serving 334 emotionally handicapped adolescents, which made up 6.1 percent of program clients.

The Rehabilitation Services Division runs four programs which help disabled persons to secure and retain employment. Older adolescents are served by the programs, though most clients are adults. All clients have medically diagnosable disabilities including mental illness, mental retardation, and orthopedic (physical) disabilities.

Data on the four programs is not collected by age or disability, making it impossible to determine accurately how many emotionally disturbed clients are served and how much is spent on them. Very rough estimates would suggest expenditures in these four programs for emotionally disturbed adolescents at about $470,000 for FY '91.

Calculations to determine what portion of their clients were adolescents assumed that expenditures were evenly distributed across the age range served.

Estimates on the number of mentally ill clients among total client populations varied by program and were provided by the department. Data on total expenditures for each program is considered accurate.

The Vocational Rehabilitation Program, designed to assist disabled persons to find and keep jobs, is estimated to have spent $330,000 on mentally ill adolescents in FY '91.

The Transition Program, whose data is somewhat more accurate because it serves only high school juniors and seniors in their transition to the workforce, served a total of 466 clients in FY '91, 20 percent of whom were estimated to be emotionally or behaviorally disturbed -- 93 clients.

Estimated program expenditures for emotionally disturbed adolescents were $44,500. These program expenditures are a subset of the Vocational Rehabilitation Program Expenditures.

The Extended Employment Program, which provides work activity and on-the-job training, is estimated to have spent $133,000 on mentally ill adolescents in FY '91.

The Independent Living Program, which serves primarily physically disabled persons, helps clients learn the skills needed to maintain long term employment. It is estimated to have spent $7,500 on mentally ill adolescents.

Total Department of Jobs and Training expenditures on emotionally handicapped adolescents for 1991 was $1.12 million.

JUVENILE JUSTICE EXPENDITURES

The Department of Corrections funds some screening, outpatient clinical services, and clinical services for emotionally disturbed children in correctional placement. These services are funded by the state Legislature.

But the department is only a bit player in overall corrections activity. Far more influential are the local probation officers and district judges who order large expenditures of social services dollars for juvenile probation clients.

The precise amount of the Department of Corrections effort is not available since the department's data does not distinguish clients with emotional disturbance. Projected 1991 expenditures of $847,000 for children's mental health services were based on the department's judgment that 10 percent of its clients in the Red Wing and Sauk Centre correctional facilities are emotionally disturbed.

Based on that estimate, the state corrections department contributes an additional .6 percent beyond DHS and Department of Education expenditures for children's mental health services. With an estimated 480 emotionally disturbed clients in corrections placements, the expenditures equal $1,765 per client.

Yet Department of Corrections expenditure data vastly understates the fiscal impact of the corrections system on children's mental health.

Local corrections officers claim most of their clients are emotionally disturbed, suggesting a far greater impact. For example, the juvenile corrections director in Hennepin County estimates that as many as 80 percent of his clients are emotionally disturbed.

The anecdotal evidence indicates that the corrections system's greatest fiscal impact is from court-ordered expenditures of social services dollars. Again, quantifying this claim is difficult, but available data is suggestive.

Since more than one-third of DHS-administered children's mental health dollars pay for Rule 5 residential treatment, an examination of Rule 5 placement of juvenile probation clients can be used to suggest the corrections system's overall impact.

In Hennepin County, approximately 56 percent of all Rule 5 placements were ordered by the courts for juvenile probation clients. The county social services department - not the local corrections department - picked up the tab.

If Hennepin County's experience is projected over statewide Rule 5 expenditures, court-ordered social service expenditures for Rule 5 placement of probation clients is approximately $22 million.

PRIVATE INSURANCE EXPENDITURES

An estimated $31.6 million was spent on privately insured children aged 0 to 18 for mental health services in CY 1991. This estimate includes expenditures for children insured by profit-making and non-profit insurers as well as health maintenance organizations.

The figure was derived from actual expenditures from a specific insurance carrier which were then projected across the state insurance market on the basis of estimates of that carrier's market share. The figure represents costs actually paid for services, not additional premiums for mental health services.

An estimated 58 percent of the total private insurance expenditure was for inpatient treatment. Approximately 36 percent paid for outpatient treatment in clinic settings, while 6 percent was outpatient treatment provided in a hospital setting.

RELATIVE EXPENDITURES FOR RESIDENTIAL /NON-RESIDENTIAL SERVICES

Since human services, education, and corrections expenditures encompass the vast majority of dollars spent on emotionally disturbed children, a nearly system-wide picture of the relative expenditures of residential and non-residential services can be made by reviewing expenditures in these three areas.

The residential/non-residential expenditure disparity does not appear as great when viewed from a multi-agency perspective as it does when only human services expenditures are considered. (See Figure 9)

The multi-agency cost of treating and educating emotionally disturbed children in residential placements (Rule 5 facilities and RTCs) was approximately 28 percent of 1990 expenditures by the three state agencies on emotionally disturbed children. Acute care hospital treatment cost an additional 7 percent. Together they total 35 percent of all state agency expenditures on this population.

By comparison, 26 percent of the inter-agency dollars were spent for non-residential treatment and support services, excluding therapeutic support for foster care.

(The rest was spent on special instruction, community education, screening, emergency services, therapeutic foster care, and state administration).

SERVICES FOR CHILDREN WITH EMOTIONAL DISTURBANCE
FEDERAL, STATE, AND LOCAL FUNDING

Services	Human Services FY 1990 Funding*	AA/GAMC Charges FY 1990**	Special Education 1990 Funding	Corrections FY 1990	TOTAL:
Special Instruction			$ 40,328,141		$ 40,328,141
Education/ Prevention	$ 332,122				$ 332,122
Emergency Services	$ 629,702				$ 629,702
Screening	$ 285,074			$ 40,000	$ 326,574
Early ID, Intervention	$ 201,573		$ 1,456,744		$ 1,658,317
Outpatient Services					
Clinical Services	$ 4,097,597	$ 4,805,000			$ 8,977,597
Related Services			$ 1,942,325		$ 1,942,3[illegible]
Case Management	$ 3,504,587	$ 11,500	$ 2,913,487		$ 6,429,574
FCSS:					
Day Treatment					
Clinical Services	$ 4,008,094	$ 543,130			$ 4,551,224
Instruction			$ 1,942,325		$ 1,942,325
Home Based Treatment	$ 1,862,122				$ 1,862,122
Therapeutic Foster Care	$ 1,251,078				$ 1,251,078
Other FCSS	$ 498,008				$ 498,008
Residential/RTC:					
Clinical Services***	$20,267,149	$ 4,233,877		$ 696,400	$ 25,231,026
Instruction			$ 4,680,078		$ 4,680,078
In-patient Acute Care Services	$ 305,190	$ 7,050,000			$ 7,355,190
State Administration	$ 99,000		$ 80,000		$ 179,000
TOTAL:	$37,341,296	$16,643,507	$ 53,343,100	$ 736,400	$108,174,403

* Totals are derived from 1990-91 county children's mental health plans.
** Totals are approximated and are not equal to payments on a claim-by-claim basis; they do not include amounts from pre-paid plans.
*** Include Room and Board costs.

Figure 9

This expenditure data, alone, offers no indication of the cost effectiveness of community-based services to an individual child.

COST-EFFECTIVENESS OF COMMUNITY-BASED SERVICES

Nearly everyone in the mental health field would agree with the claim that home and community-based services are cheaper than residential treatment or hospitalization. Intuitively, it feels like a safe bet. If parents are providing basic care such as housing, food, and clothing while therapy is provided in the home or school or on an outpatient basis, it must cost the public less than when government pays for all of the child's care as in a group home, regional treatment center, or hospital.

While intuition may prove correct, no definitive studies have been conducted in Minnesota that quantify the fiscal benefits of community-based services.

Initial indications from local demonstration projects in Minnesota suggest that long-term client-specific cost savings are likely to occur as the community-based treatment approach is increasingly used. At the very least, studies of adult mental health services have produced strong evidence that the availability of community-based services reduces the need for residential placement. Most recently, statistics from the 15 counties receiving federal mental health block grant funds for adult community-based demonstration projects show that, of the 93 individuals who were either relocated to the community or diverted from inpatient treatment, 87 are being maintained successfully in the community and have not required psychiatric hospitalization.

Nevertheless, there have been no studies in this state comparing the cost of the entire package of community-based services which must be used to replace residential treatment. That is, a package of several services is commonly used in the community-based approach and the cost of the total package must be taken into account when comparing the cost to residential treatment.

A 1989 study by the Legislative Auditor's Office attempted to determine the cost-effectiveness of community-based services for adults and concluded: "There is too little information available to conclusively judge the relative cost-effectiveness of treatment settings in Minnesota."

Even if community-based services prove cheaper on a client-by-client basis, it is possible that their availability may encourage unserved clients to come forward, thereby consuming any cost savings.

Quantifying the initial intuition would require long-term, child-specific case studies. The life-long cost of treating children who had been served within a community-based model would have to be compared to the cost of services provided to children treated within a residential model. Simply comparing the cost of a community-based service to that of a residential service proves nothing. The community-based model calls for providing multiple therapeutic, support, and case management services in a package. The cost of providing the entire package would have to be measured.

Even comparing the cost of service packages at any point in time would demonstrate very little, however. The true savings to be realized from community-based treatment, with its implied intervention at an early stage of emotional disorder, results from avoiding long-term, intensive therapy throughout a child's life.

It is when early intervention is factored into the comparison that intuition feels most confident. Treating an emotional disturbance at its onset must certainly be cheaper than waiting until it is severe and requires more intensive treatment. But this is not the issue: early intervention should not be assumed to be community-based treatment and late intervention should not be assumed to be residential or institutional treatment.

Any cost comparison study would, further, have to account for several problems: (1) The study would have to measure effectiveness of life-long treatment to ensure that a comparison is being made between treatment programs that produced similar results. A treatment program that ultimately transfers an 18-year-old to Stillwater prison might have been cheaper than a program that results in a productive adult. (2) Clients in inpatient settings may be different than those in community treatment, thus thwarting direct comparison. (3) The cost of care depends to some extent on the salary levels of service providers in both residential and outpatient settings.

Proponents of a community-based model of service delivery don't base their advocacy on cost-effectiveness. Community treatment is promoted as a more effective treatment approach and is preferred out of concern for the client's quality of life. Further, it should be clear that the fiscal efficiency of the children's mental health system is in no way defined by the debate over community versus residential treatment. Professionals in the system currently believe there is a role for both treatment approaches. This report attempts to address ways to improve the efficiency of a system that will continue to include residential treatment.

INTERRELATED EXPENDITURES OF THREE STATE DEPARTMENTS

Figure 9 suggests relative expenditures for emotionally disturbed children on specified services by three state departments. Because the data are merely projected expenditures based on 1990-91 children's mental health plans, it should be used with caution.

The projections, compared to more reliable reported expenditures for 1991, underestimate DHS expenditures by $9 million and education expenditures by nearly $12 million. Corrections data can be expected to contain similar errors.

The value of the table lies in its ability to show the interrelatedness of the human services, education, and corrections systems in the funding of key services. Note, for example, that the Department of Education pays for educational instruction of children in residential treatment facilities. For children in day treatment, DHS pays for the therapeutic portion of the child's day, while the Education pays for instructional portion.

Funding Structures / Eligibility Criteria

Funding structures control the way dollars flow to services and greatly determine the fiscal efficiency of a system.

Specifically, the term "funding structure" refers to the pots of money available from various sources, the eligibility criteria which determine how those dollars may be spent, and the incentives to provide a service or not.

An efficient system, in an economic sense, would allow an undisrupted flow of dollars to client services based solely on that client's needs and total dollars available. It is efficient, for example, when a local worker can assess a client's needs, then provide, from a single source of dollars, a package of services which is effective, non-duplicative, and not at cross purposes.

Inefficiency is created when other factors are allowed to determine how dollars are used. For example, it is inefficient (1) when a worker must piece together a funding package from a variety of sources; (2) when one child may receive services but another with the same problem may not; (3) when there are no dollars available to pay for the treatment that a child needs while money is available for an unnecessary treatment.

Several inefficiencies in the existing system are described below. The genesis of these inefficiencies is the hodge-podge development of the system. Over the years, advocates have identified various holes in the system and created pots of money to fill them. None of the current funding sources is based upon any vision of a comprehensive system.

The inefficiencies are:

#1
The Eligibility Restrictions Inefficiency

Agencies serving emotionally disturbed children are restricted not only by how much money they have to spend, but in how they can use the available dollars. Restrictions take the form of eligibility criteria.

Four types of eligibility restrictions exist in the children's mental health system. Eligibility criteria restrict:

(1) what services can be paid for;
(2) who may receive a particular service;
(3) how much of a service the client may receive; and
(4) who may provide the service to the client.

The result is that a service decision-maker faces the complex task of matching a client with particular needs to a funding source which will pay for indicated services and, then, to a provider who is both able to provide the service and eligible to receive payment from the funding source. To be more precise, a decision-maker frequently must choose the service for which dollars are available, rather than the service which will most benefit the child.

"If someone has multiple problems you pick the one that's going to be a payable one, in terms of whether they are CD, emotionally disturbed, mentally retarded," a social worker said. "You go by where can you get them in and what will it pay for. You really don't look at what does a kid need but look at what's available."

Commonly, a clinical diagnosis is actually changed so that some treatment may be provided to a child, even if that treatment is not that judged to be most beneficial.

An illustration of inefficiency may be found in Medical Assistance funds which carry all four types of eligibility restrictions. Eligibility is based on income criteria which means it is available to low-income clients. MA is primarily a medical funding source and favors medical types of services. In the mental health field, this means services to treat illness that have been diagnosed by a psychiatrist.

The sheer size of the MA fund, and the fact that it is 54 percent federal dollars and no cost to the county (except for RTC services), gives it the power to bend the system to its character. And it has, thus, bent the system toward a medical model of children's mental health care which many in the system find inappropriate.

"I know a medical model has to be in here somewhere but you've got to also throw in a social kind of a model rather than always going on just an MA basis," a county mental health worker said. "We're going to use our family community support monies to pick up what MA doesn't cover because it doesn't meet the reality of the problem. If you have a problem child and he's got an emotional disturbance, it's very difficult for the therapist to spend any time with the parent, unless they have a diagnosis, too."

A public health nurse, who works under medical supervision, said MA administrators and HMOs tend to view any service provided in the home as a social problem. "They're looking at a strict medical sense and saying, 'Bring this client into the doctor's office.' That's often not the answer."

The size of the MA fund also means that, when policy-makers are looking for new dollars, revision of MA eligibility criteria become one of their primary foci. This approach will be discussed in Section VII.

Another example of inefficiency is the Children's Community-Based Mental Health Services (Rule 78) grant which pays for non-residential treatment and community support services, but not for residential or in-patient treatment. In addition, it can be used only for those clients who fit the definition of Severely Emotionally Disturbed.

#2

The Fragmented Service Delivery Inefficiency

Because of the fragmentation of the service delivery system into independent agencies operating with different goals and using separate pots of money, all dollars are not available to all professionals who are trying to serve emotionally disturbed children. Thus, from the standpoint of a given

professional, some of the funding sources in the system are unavailable.

The same inefficiency identified with regard to dollars can be identified with regard to staff. Agencies tend to hire staff with a particular professional discipline or established set of disciplines. Social services agencies, for example, hire social workers but lack staff who are qualified to provide special educational instruction or to incorporate emotional characteristics into a pre-sentence investigation.

Thus, the agency which has access to the child does not have access to all of the resources theoretically available within the system.

#3

The County Fiscal Incentives Inefficiency

Counties, due to a hodge-podge of state and federal regulations, pay a greater portion of the cost for some services than others. Thus, county decision-makers have an incentive to choose the service which requires the fewest local dollars. The disparity is so great that, in some cases, a service which is far more expensive actually costs the county nothing.

Counties pay 68 percent of the cost for Family Community Support Services and case management, for example. (However, new grants for FCSS and case management require no local match and should result in a significant cut in the average county share for these services.) They pay 62 percent of community residential treatment. By comparison, acute care hospital treatment costs nothing in county dollars for MA-eligible children. Incentives exists, then, for the county to send a child out of his or her community rather than to provide treatment at home or in a nearby facility.

Until recently, RTC services had been cheap to counties. Now counties pay 50 percent of the non-federal share, or approximately 23 percent for MA-eligible children. Counties pay 100 percent for non-MA-eligible children.

Foster care, i.e. traditional family foster care as well as room and board costs of residential treatment, can be either very cheap to the county or expensive, depending on the child's circumstance. Federal Title IV-E dollars will reimburse counties for 54 percent of cost for IV-E eligible children, but zero percent for those not eligible.

The historic lack of fiscal incentives for counties to create community support services or case management services in order to coordinate community services means that family community support services have been non-existent in many counties. However, Children's Community-Based Mental Health Services (Rule 78) grants were initiated in 53 counties in April, 1991, and are to be expanded to 86 counties in April, 1992. Still, discussions with county administrators indicate that even these new funds will not meet what counties say they need to establish mandated community-based services.

Without adequate community support services, counties have no choice but to place children in residential treatment.

FEDERAL, STATE AND COUNTY SHARES OF FUNDING FOR SELECTED CHILDREN'S MENTAL HEALTH SERVICES

(ESTIMATED; FISCAL 1991)

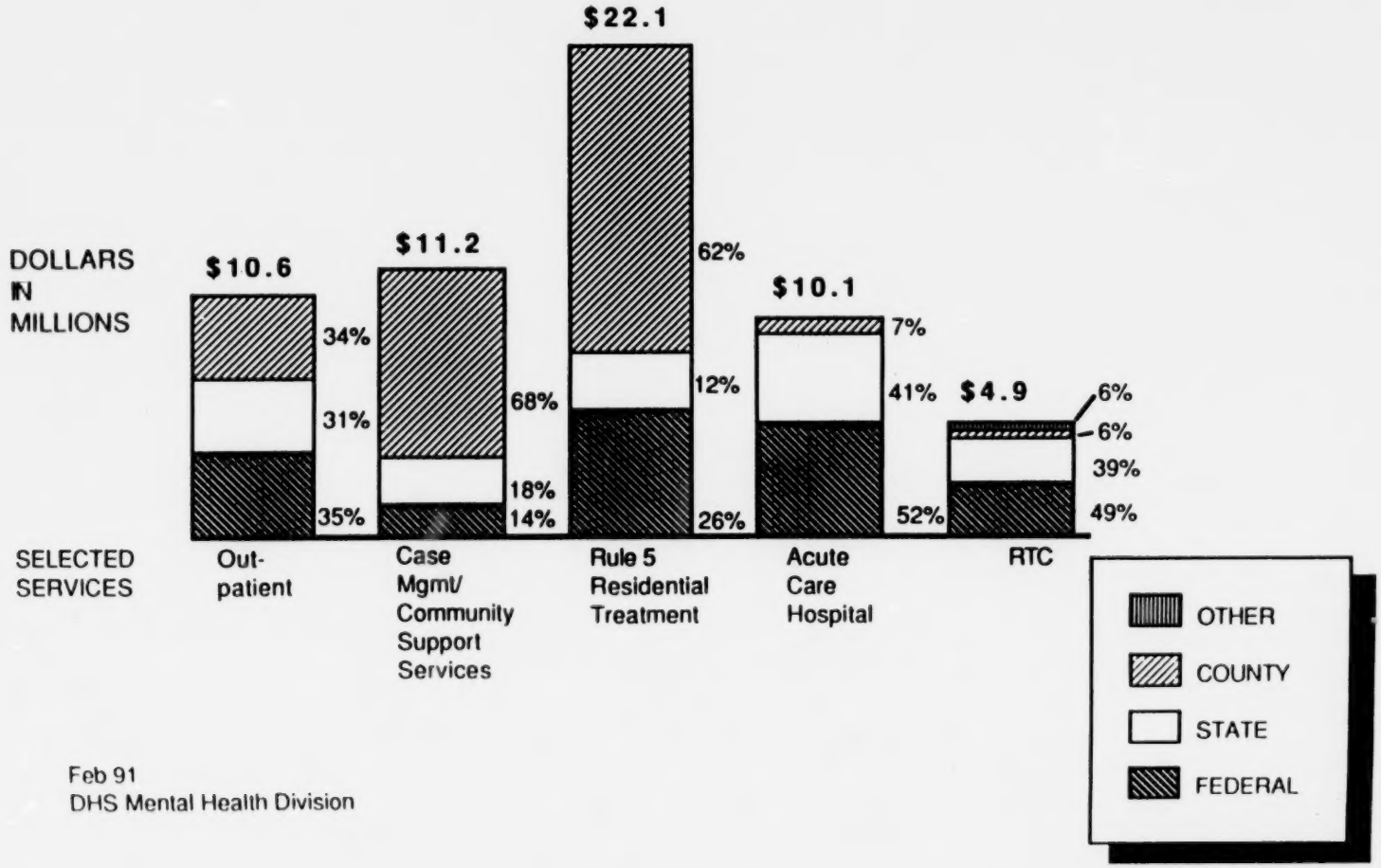


Figure 10

Figure 10 shows state, local, and federal shares for some of the major children's mental health services.

#4

The Private Insurance Inefficiency

What Medical Assistance does for low-income families, private insurance and health maintenance organizations do for middle-income families. These private insurance plans are the primary source of funds available to middle-income families for mental health services.

The private health payment system, like public medical assistance, constrains the care available by way of restrictive criteria in the coverage plan which lists services for which the plan will pay and by ceilings on any specific service available to a client.

In fact, many families with private insurance have mental health coverage that is inferior to that available to public assistance clients. Children who qualify for Medical Assistance have access to a wider array of services and, in many instances, longer duration of coverage than that available to private payment clients. "We're better off if the family is involved with social services because then they have medical assistance," an EBD teacher said.

"If the students are involved with public funding in some way, it seems usually it will get worked out somehow. If they're involved with an HMO or some other insurance carrier, then the rule seems to be that the more you need the help, the less likely that you're going to get anything. It's almost always an inverse relationship. If all you need is a prescription and that keeps some kind of behavior under control, you'll probably get that. But if you need family therapy or extensive involvements, the more serious the problem, the less likely you'll get it through any of the private carriers."

A 1991 DHS study of mental health providers, agencies, and associations corroborated evidence from our case studies. Mental health providers, in that study, expressed a concern that the mental health system would shift toward inpatient, medically oriented treatment because of private insurance companies' refusal to pay for outpatient psychiatric and psychosocial services.

Private insurers usually cover inpatient treatment and, by state law, also cover outpatient therapy. Private insurers tend to disallow payment for ancillary services such as day treatment, home-based treatment, or crisis services.

Coverage limits make private insurance nearly useless for some families. One mother of an emotionally disturbed son said: "We have a Blue Cross/Blue Shield family policy. They did not cover the $2,000 evaluation. He costs $75 a week for therapy; they do not cover that. It's $63 a month for medication; they will not cover medication because it's an emotional disorder."

According to a 1990 report by the State Advisory Council on Mental Illness, the denial of mental health services is particularly acute with HMOs, which claim such services are not "medically necessary".

The report stated: "There are numerous limitations applied to the coverage of mental health treatments, whereas no similar limits are applied to physical conditions which are covered benefits." Such inequities, the Council said, are due to federal and state insurance laws. Thus, private insurance is within the scope of an analysis studying the feasibility of public initiatives.

Minnesota Statutes, Chapter 62A regulates private health and accident insurance policies. One example of the limits state insurance laws place on mental health coverage is contained in Chapter 62A.151. It mandates coverage for the treatment of emotionally handicapped children in a licensed residential treatment facility on the same basis as inpatient medical coverage. However, it excludes from the mandate "any plan or policy which is individually underwritten or provided for a specific individual and family members as a non-group policy."

Chapter 62A.152 defines ambulatory mental health benefits for group policies and non-profit pre-payment plans. It mandates minimum coverage for out-patient treatment by a community mental health center or clinic, including treatment provided by a licensed psychologist or psychiatrist. However, it requires prior authorization from the insurer for treatment beyond ten hours and provides non-specific criteria for determining that authorization. It further allows insurers to limit extended treatment to 30 hours per year.

Employer's health benefit plans are subject to the same benefits and limits for outpatient mental health as defined in the paragraph above, according to Chapter 62E.06, Subs. 1(g).

Chapter 62D regulates health maintenance organizations. Chapter 62A.102 sets a ten-hour minimum for outpatient mental health treatment and mandates coverage of family therapy for the treatment of a minor. But, again, it requires prior authorization from the HMO for treatment beyond 10 hours, with authorization based on non-specific criteria, and allows the HMO to limit extended treatment to 30 additional hours per year. Plus, coverage can be limited to 75 percent of the cost of the extended treatment.

Our case studies revealed great dissatisfaction among local workers regarding HMO coverage of mental health services. They cited limitations on the amount of services which would be provided; long waits for services; and refusal to address symptoms identified by social workers or educators.

"Their intake process is designed to screen people out," a county probation director said. "You have to have a great deal of skill to maneuver your way through the system. Most parents do not know how to do that. Whether the obstacles are there intentionally to discourage, I don't know. They simply function that way for most people."

"What we resent," said a child psychiatrist with a Minnesota foundation, "is that some of the people we deal with are in HMOs that are neglecting their duty to treat the kids." A school psychologist agreed: "That's getting worse. I have spent a lot of time arguing with HMOs to get services that this

person deserves as per their contract. If you lean on them and you build a good case, they'll provide it."

HMOs tend to deny utilization of providers outside of their own networks; this can break long-established therapeutic relationships. "They would have to start all over again with someone else, so you lose some of the continuity and consistency with the care." a protection worker said of her clients' experience.

Chapter 62D.103 requires an HMO to evaluate an enrollee who is seeking treatment for a mental health condition. If treatment is denied, the enrollee is guaranteed a second opinion by an outside mental health professional, but the HMO "is not obligated to accept the conclusion of the second opinion."

#5

The SED Definition Inefficiency

Children's Community-Based Mental Health Services grants must be used to fund services to children with a diagnosis of Severely Emotionally Disturbed (SED).

There is some controversy regarding this restriction. The Comprehensive Children's Mental Health Act (M.S. 245.4886), regarding the use of CCBMHS grants, states: "The commissioner shall establish a statewide program to assist counties in providing services to children with severe emotional disturbance...and their families." The Department of Human Services, Mental Health Division, has interpreted this language to preclude using these grants to pay for services to non-SED children. At least one children's mental health advocate disputes the interpretation. Rule 78, which will govern use of the funds, will not likely resolve the dispute because it merely refers back to statutory language.

Rules governing another funding source, the Federal Mental Health Block Grants, give priority to SED children, according to DHS interpretation.

In order to classify a child as SED, one of the following criteria must be met:

(1) admission within the last three years or at risk of admission to residential or in-patient treatment;

(2) a Minnesota resident receiving treatment for an emotional disturbance through interstate compact;

(3) determination by a mental health professional that the child has a psychosis or clinical depression, presents a risk of harming self or others or has psychopathological symptoms resulting from abuse or trauma within the past year;

(4) has impaired home, school, or community functioning as a result of emotional disturbance that has lasted at least one year or, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

DHS has estimated that the SED designation will provide services for twice as many children as the "seriously mental ill"

designation which covered children prior to passage of the Comprehensive Children's Mental Health Act. Nevertheless, county-level decision-makers claim that many severely disturbed children are not classified as SED.

There are two common reasons, according to local workers. In frequent instances, a service provider who both diagnoses an illness and pays for treatment, such as an HMO, refuses to diagnose an illness that it would then be forced to treat. Sometimes, therapists and educators resist placing the stigma of a mental illness label on a child.

While, children's advocates have, for the most part, convinced the professionals that ıgnostic stigma can retard a child's progress, our case studies, ironically turned up parents who said the unwillingness to label children sometimes can delay treatment.

"Professionals do not want to label or diagnose kids," said the mother of a 16-year old emotionally disturbed son. "I can understand it but sometimes a kid needs a diagnosis. Unfortunately, in our case, a diagnosis was needed a long time ago."

The impact of this inefficiency is greatest on the non-residential end of the service continuum - such as home-based treatment, community support services, and case management - because many communities are relying on the CCBMHS grants to establish these new services.

Local communities tend to compensate by providing services for undiagnosed children with local discretionary funds. However, training case workers in the subtleties of the funding system costs the county time and dollars.

#6
The Inflexible Resource Inefficiency

When resources cannot be quickly shifted within the system to meet demand, those resources lack flexibility. Staff in county social services agencies and schools is a prime example of an inflexible re: ırce. If, in a given week, EBD children in a school have an extraordinary need for psychotherapy and a decreased need for the school social worker, then the set staff ratios create an inflexibility that inhibits efficient delivery of the services which the children need.

However, inflexible staff resources constitute an inefficiency only in some settings. In many agencies, demand on staff is so relentless that they are never underutilized. Only in those settings where demand for staff occurs in peaks and valleys, creating periods of underutilization, does inefficiency result.

Provision of services via fee-for-service agencies reduces the inflexibility. Nevertheless, those agencies are likely to have built into their fees the costs of their own fluctuating staff demand.

#7
Providers And Agencies Don't Get Paid For Coordination Activities

The fundi structure and billing rules provide a disincentive against case

coordination and interagency collaboration because agencies and providers don't get paid for it.

Neither Medical Assistance nor private insurance pays providers for "collateral contacts" -- the time spent coordinating their services with other providers and agencies. Without the ability to bill directly for coordination services, providers must make up the cost elsewhere in their budgets.

Public agencies are under pressure from the Legislature to develop protocols for interagency collaboration, but the Legislature has not funded coordination activities. Not even the new Children's Community-Based Mental Health Services (Rule 78) grants pay for coordination.

Counties and schools are forced to absorb collaboration costs in their administrative budgets. "Collaboration takes a tremendous amount of time," a social services supervisor said. "That time is taken away from direct supervision of social workers, so our whole system is diluted. Those are wonderful things to do but no one has given us the resources."

Time studies on the resources required for coordination are unavailable, but professionals have estimated that they spend from 20 to 30 percent of their time on case coordination and interagency collaboration. (This does not include an estimated one-fifth of a social worker's time spent on compliance standards paperwork.)

#8

The Regional Treatment Center Inefficiency

Minnesota currently supports a regional treatment center system which demands dollars that are not flexible in their use, due to the nature of fixed-costs institutions. As the cost of RTC services climbs, the client population falls, making RTC placements increasingly expensive to counties who lack alternative providers in their communities.

Dedicated state RTC dollars come under frequent criticism as encouraging institutional placement. The point has some validity in the sense that those dollars are not available for other types of services. However, dollars expended on children for RTC services -- less than 8 percent of DHS expenditures for children's mental health services (see Figure 7) -- are too few to distort the system greatly.

#9

The MA/GAMC Reimbursement Rates Inefficiency

Rates paid for children's mental health services by Medical Assistance (MA) and General Assistance Medical Care (GAMC) are so low as to discourage the number and types of providers willing to take emotionally disturbed clients, according to recent literature.

Since MA and GAMC are primary funders of mental health services for low-income people, any shortage of MA-enrolled providers is likely to have a disproportionate impact on services available to low income children.

A 1991 study of mental health providers, agencies, and associations by the Mental Health Division of DHS identified reimbursement disparities among licensed mental health professionals. Reimbursement rates for psychotherapy, in particular, "continue to plunge," according to a draft report on the study.

The study also identified continuing reductions in MA reimbursements for mental health services. It blamed the low MA reimbursement rates for "fiscal shortfalls which restrict quality and quantity of services". This results in the failure of MA provider agencies and a shortage of qualified professionals who are willing to provide services to MA clients. It also blamed the reimbursement rates for negative impacts on client care and recidivism.

The impact of the rate structure probably will be mitigated to some extent by the passage of the 1992 Health Right law which raises MA reimbursement rates for outpatient and physician services. In addition, all vendors who provide health care for state employee health insurance, public employees insurance plans, workers compensation, and the Minnesota Comprehensive Health Association will be required to provide services to MA, GAMC, and Health Right clients.

ELIGIBLE DOLLARS WITHIN THE EXISTING FUNDING STRUCTURE

Figure 11 shows which funds may be used to pay for the various children's mental health services. For example, an "X" directly to the right of "day treatment" in the "Medical Assistance" column means that day treatment is eligible for MA reimbursement.

The dollar figure listed underneath each fund is the amount spent from that fund on children's mental health services during the most recent year for which data is available. Please note that Medical Assistance and Title IV-E are entitlement programs, so expenditure levels in these program could change relative to the other programs if demand increases or decreases.

The table shows the dollars for which each service is eligible. **It does not show actual expenditures.**

The far-right column, "Total Eligible Dollars," displays the total funding which **could be** available for a service within the existing funding structure if local authorities would so choose. The figures assume that all dollars from a particular fund would be allocated to only one service.

The column demonstrates the relative theoretical availability of funds to each DHS-administered children's mental health service at current funding levels.

Several conclusions may be reached from these calculations. First, it shows that there

DHS CHILDREN'S MENTAL HEALTH FUNDING PROGRAMS

(Dollars in millions)

	COUNTY SOCIAL SERVICE FUNDS	MEDICAL ASSIST	MA RTC	TITLE IV-E	CCBMHS (Rule78)	FED MH GRANT	FAMILY PRESERV	CHILD HEALTH PLAN	TOTAL ELIGIBLE DOLLARS**
	$37.00 ('90)	$14.00 ('89)	$4.00 ('90)	$3.53 ('91)	$3.36 ('92)	$0.67 ('91)	$0.12 ('91)	$0.06 (CY 91)	62.74
Case Mgt.	X	X			X	X			55.03
FCSS	X				X	X			40.43
Day Treatment	X	X			X	X			55.03
Home-based Tx	X	X			X	X	X		55.15
Outpatient	X	X				X		X	51.73
Early ID/Interv	X					X			37.67
Educ & Prevent	X					X			37.67
Therap Foster	X			X *	X	X			44.56
Emergency Serv	X								37.00
Screening	X								37.00
Residential Tx	X			X *					40.53
Acute Hospital	X	X							51.00
RTC Services	X		X						41.00

* Case management and housing only. No treatment.

** "Total Eligible Dollars" refers to the funding that could theoretically be available for a service if local communities would so chose. It assumes that all dollars from eligible funds would be allocated to only one service. This column does not show actual or projected expenditures.

Figure 11

is less eligible money to pay for Early Identification and Intervention services than for Professional Home-Based Family Treatment, Day Treatment, or Residential Treatment. Thus, services designed to intervene at the earliest stages of an emotional disorder are underfunded relative to services designed to treat a child after a disorder has had a chance to intensify.

A second conclusion may be reached: More money is eligible to pay for non-residential services than for residential services. The fact that funds are not actually spent in these proportions is not a function of the funding structure's restrictions per se.

FUNDING STRUCTURE IS NOT A BARRIER TO COMMUNITY-BASED SERVICES

Analysis must conclude that the funding structure of the children's mental health system is inefficient. As such, it is a barrier to re-creation of a more effective and efficient system. But is it a barrier to establishing home and community-based services?

The funding structure, itself, is not a primary barrier to a community-based children's mental health system. In order to conclude otherwise, analysis would have to determine that the system fails to provide dollars to the array of treatment and support services which comprise a community-based system.

While eligibility criteria make it extremely difficult to match many clients with funding sources that can pay for the services they need, the community-based services, themselves, are eligible for broad and considerable funding. Making the system work for any individual client can be an administrative nightmare, the very embodiment of inefficiency. However, dollars eligible to provide community-based services to these clients exist within the existing funding structure. Much more money could be spent on community-based services than is currently being spent.

In fact, funds whose eligibility criteria allow them to pay for home-based and community support services are sufficient enough in the current system to fully implement the Comprehensive Children's Mental Health Act. (See Figure 11.)

That the dollars are not made available to non-residential service providers is the result of local treatment and funding choices in response to client demand. Because local decision makers continue to demand residential and hospital treatment, counties have not reallocated sufficient funds to create adequate community-based services.

If the community-based services are eligible for dollars, why is it that local professionals continue to maintain that "the dollars are not there" for home and community-based services?

The answer may lay in the very nature of the demand communities face. Although it is true that counties could reallocate funds from residential treatment for the most severe cases which absorb the majority of dollars available, it is not clear that a responsible person would advocate doing so. As will be discussed at greater length in the following "Service Delivery and

Availability" section of this report, reducing services to the most severely disturbed children poses danger to the client and to society and, ultimately, costs even more money.

TABLES OF DHS FUNDING SOURCES WITH ELIGIBILITY CRITERIA

The following tables show each of the major Department of Human Services funding programs. The makeup of the fund is shown as well as the possible uses and limitations of the dollars.

"COUNTY SOCIAL SERVICES FUNDS"

ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES

($37 million in 1990)

1) Funding source (federal/state/local CY '91)

(a) Fed Title XX - 12%
(b) State CSSA - 14%
(c) Local Levy - 74%

2) What services will it pay for?

(a) Local discretion

3) Who is eligible for these funds?

(a) Local discretion

4) Limitations on eligible services

(a) Local discretion

5) Providers whose services may be paid with these funds

(a) Local discretion

"MEDICAL ASSISTANCE"
ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES
($14 million in 1989)

1) Funding source (federal/state/local)
   (a) Federal - 54.43% (b) State - 45.57%

2) What services will it pay for?
   (a) Case Management
   (b) Day Treatment
   (c) Home-Based Treatment
   (d) Outpatient Treatment
   (e) Acute Care Hospital
   (f) Medications

3) Who is eligible for these funds?
   (a) Those who are **categorically** needy such as either:
      (i) AFDC eligible
      (ii) MSA eligible
      (iii) SSI eligible

      Family income may be as high as 133 1/3 percent of the AFDC eligibility standard for families and children; less than 133 percent of the federal poverty level for children aged 1-5; less than 100 percent of the federal poverty level for children aged 6-7.
   (b) Those who are **medically** needy, i.e. those whose medical bills reduce income below the eligibility threshold.

4) Limitations on eligible services
   (a) Case management is limited to 6-10 hrs per mo.
   (b) Day treatment is limited to 360 hrs. a year for clients not on public assistance, i.e. "medically needy".
   (c) For home-based treatment, public assistance is required after the first treatment episode.
   (d) Out-patient psychotherapy is provided in individual, group, and family settings, each with a distinct base benefit level.
   (e) Acute hospital care has no limits.

5) Providers whose services may be paid with these funds
   (a) physicians
   (b) psychiatrists
   (c) psychologists
   (d) hospitals
   (e) medical clinics
   (f) community mental health clinics and centers
   (h) county social service agencies my be enrolled as a health care provided for case management services. Staff must be masters level psychiatric nurses or licensed independent clinical social workers.

"FAMILY PRESERVATION GRANT"

ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES
($4.7 million in 1992)

1) Funding source (federal/state/local)

(a) Federal Title IV-B - 27.7%
(b) State Family Preservation Grant - 72.3%

2) What services will it pay for?

(a) Professional Home-Based Family Treatment

3) Who is eligible for these funds?

(a) County discretion but normally for children who:
- are at risk of out-of-home placement
- have a goal of reunification
- are at risk of maltreatment
- have a severe emotional disturbance

(b) Services provided to the limit of each county's grant.

4) Limitations on eligible services

(a) Local discretion: local service contracts set duration and amount of service each client may receive; generally the duration is four to six months.

5) Providers whose services may be paid with these funds

(a) County social service agencies
(b) Agencies under contract with a county

"MEDICAL ASSISTANCE - REGIONAL TREATMENT CENTER"

ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES
($4 million in 1990)

1) Funding source (federal/state/local)

(a) Federal - 54.43%
(b) State - 22.79%
(c) Local - 22.79%

2) What services will it pay for?

(a) Regional Treatment Center placements

3) Who is eligible for these funds?

(a) Those who are **categorically** needy such as either:
(i) AFDC eligible
(ii) MSA eligible
(iii) SSI eligible

Family income may be as high as 133 1/3 percent of the AFDC eligibility standard for families and children; less than 133 percent of the federal poverty level for children aged 1-5; less than 100 percent of the federal poverty level for children aged 6-7.

(b) Those who are **medically** needy, i.e. those whose medical bills reduce their income below the eligibility threshold.

4) Limitations on eligible services

(a) Same as other MA services

5) Providers whose services may be paid with these funds

(a) Regional Treatment Centers in Willmar and Brainerd

Title IV-E ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES ($3.53 million in 1991)

1) Funding source (federal/state/local)
   (a) Federal - 100%
      [Title IV-E funds reimburse counties, on a client-by-client basis for 54.43% of their substitute care costs for IV-E eligible children.]

2) What services will it pay for?
   (a) The costs of maintaining a child in a substitute care setting including: food, shelter, clothing, supervision, and supplies;
   (b) Additional maintenance costs resulting from a child's emotional, physical, or mental handicap.

3) Whose services may be reimbursed with these funds?
   (a) Children for whom the local social service agency has responsibility for care either by court order or voluntary placement agreement with the parent(s);
   (b) Children must be eligible to receive AFDC but must not be actually receiving it;
   (c) Children up to their 18th birthdays or, if expected to complete high school by age 19, until their 19th birthdays or graduation;
   (d) Refugee children.

4) Limitations on eligible services
   (a) No mental health treatment or medical services may be paid with IV-E dollars;
   (b) Payments for refugee children are limited to the first 31 months after the child enters the U.S.
   (c) All individuals who meet eligibility criteria are entitled to services for an unlimited time under IV-E rules but the state imposes rates on Rule foster care settings and groups homes have individual rates negotiated with the county responsible for the child.
   (d) Two year limit on stays in pre-adoption homes, after which adoption must be finalized.

5) Providers whose services may be paid with these funds
   (a) Family foster homes licensed by Rule 1; Department of Corrections; or a tribal board
   (b) A relative's home if it meets Rule 1 standards or a waiver has been granted by DHS
   (c) Rule 5 residential facilities which have been approved by DHS
   (d) Group residential facilities licensed by a tribal council or the Department of Corrections and approved by DHS
   (e) Pre-adoptive homes

"CHILDREN'S COMMUNITY-BASED MENTAL HEALTH SERVICES GRANT" ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES ($2.16 million in 1992)

1) Funding source (federal/state/local)
   (a) State - 100%

2) What services will it pay for?
   (a) Family Community Support Services:
      (1) crisis assistance
      (2) client outreach
      (3) medication monitoring
      (4) independent living skills
      (5) parenting skills
      (6) recreational activities
      (7) respite and special day care
      (8) assistance obtaining financial benefits
   (b) Day treatment
   (c) Professional home-based family treatment
   (d) Therapeutic support for foster care
   (e) Case Management (mandatory 30% of each county's grant)

3) Who is eligible for these funds?
   (a) Children diagnosed as Severely Emotionally Disturbed

4) Limitations on eligible services
   (a) Only FCSS services and case management can be paid for
   (b) Grant priority is given to counties who show intentions to develop, fund, and deliver services in cooperation with other agencies.
   (c) Services provided only to the limit of each county's grant

5) Providers whose services may be paid with these funds
   (a) County social service agencies
   (b) County mental health agencies
   (c) Community mental health centers
   (d) Private mental health providers
   (e) Schools
   (f) Public health agencies
   (g) Volunteer and service agencies (YMCA, 4H, youth camps)

"FEDERAL MENTAL HEALTH BLOCK GRANT"
ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES
($674,000 in 1991)

1) Funding source (federal/state/local)

(a) Federal - 100%

2) What services will it pay for?

(a) Case management
(b) Family Community Support Services
(c) Day treatment
(d) Professional Home-Based Family Treatment
(e) Outpatient treatment
(f) Early Identification and Intervention
(g) Education and Prevention
(h) Therapeutic support for foster care

3) Who is eligible for these funds?

(a) SED children are a priority

4) Limitations on eligible services

(a) State discretion: Minnesota has been using these dollars to fund:
- an eight-county Children's Mental Health Demonstration Project. The project must be based on the Child Adolescent Service System Program (CASSP) model for interagency community-based service delivery; and
- ten projects serving American Indians.

(b) Services provided to the limit of the grant.

5) Providers whose services may be paid with these funds

(a) State discretion: For the purposes of the demonstration project, providers vary by county. Examples include county social service agencies, county mental health agencies, schools, and public health agencies.

"CHILDREN'S HEALTH PLAN"
ELIGIBILITY LIMITATIONS FOR CHILDREN'S MENTAL HEALTH SERVICES
($59,000 in 1991)

1) Funding source (federal/state/local)

(a) State - 100%

2) What services will it pay for?

(a) Outpatient mental health service, limited to:
- diagnostic assessments;
- psychological testing;
- explanation of findings;
- individual, family, and group psychotherapy

3) Who is eligible for these funds?

(a) Children age 1 through 17
(b) Children whose gross family income is equal to or less than 185 percent of the federal poverty guideline if they are not covered by MA, GAMC, or private insurance.

4) Limitations on eligible services

(a) $1,000 annual limit for mental health services per child
(b) Any number of eligible children may be served since there is no cap on total program expenditures.

5) Providers whose services may be paid with these funds

(a) Any provider participating in the Medical Assistance program.

Service Delivery and Availability

Minnesota is struggling to resolve a conflict between two distinct service delivery strategies.

According to common wisdom, the conflict is between residential and community-based services. There is some truth to the notion. They represent the old and the new generations of mental health care, with community-based services fighting for ascendancy. With it goes a competition for resources and for the hearts and minds of professionals and regulators.

But viewing the conflict in this manner is distracting. From the standpoint of the local worker, the residential and community-based approaches are not separate systems but two necessary components of a whole. In all likelihood, the future of children's mental health will include both types of services.

It is far more useful to view the conflict as a struggle over the timing of service delivery: At what stage of an emotional disorder should intervention occur?

The real struggle for the new generation of community-based services is to obtain resources necessary to intervene at the earliest possible stage, before a disorder becomes severe.

In this view, the residential vs. community services debate is a factor because residential treatment is commonly used to respond to the crises of severely disturbed children, whereas community-based services are more focused on prevention and early intervention. Nevertheless, the residential vs. community competition does not define the issue.

Treatment in hospitals, group residential settings, and correctional facilities still dominates the mental health system's financial resources despite a state policy which promotes home and community-based treatment for both children and adults.

Historically, in-patient/residential treatment has been the only choice. Today, debate rages over the efficacy of residential treatment as illustrated by this debate from our case studies:

Some children benefit in residential settings primarily because, whether you have a locked door or not, you have kind of a closed world where you can deal with things and have some ability to follow through," according to a psychiatrist. "You try to reduce the size of the child's world to manageable tasks."

"The problem," according to a protection worker, "is that if you take this kid out of his family, out of his neighborhood, out of his environment and stick him in this nice little building for six to eight months and do this structured, intense service, he'll benefit from it and learn some things. But then you take him out and put him back in his family where there's been no family therapy, the success that he had in residential treatment might not carry over."

"I would see that as part of the expectation," the psychiatrist responded,

"that the family and local resources are involved each step of the way. You don't just release this person. You have the family demonstrate that they're ready for his return and the school program in place. You plan for the setting he's going back to."

"Even the best laid plans fall apart."

Residential treatment may benefit the most severely disturbed individuals who need either (1) treatment of such intensity that it can be provided only in a controlled environment and/or (2) a safe environmental away from their normal circumstances.

By contrast, treatment in normal environments such as home, school, or community is thought to provide more realistic surroundings and help the client learn how to cope with the environment in which he or she must live. It is easy, proponents say, to treat someone in a controlled environment. But gains are lost when the client confronts the shock of returning to a home, a family, and a community that have not changed with him. In addition, they say, forcing an emotionally disturbed child into a strange, lonely setting deprives the child of what little support and comfort he/she was able to muster from familiar surroundings. That displacement, in itself, is sufficient to traumatize many individuals and bring on mental illness.

Community-based treatment can play a preventative role. Because services are located where people live, early problems can be identified before they become severe. Even severely disturbed individuals can benefit from therapy in their own homes or communities.

Community-based treatment cannot function on its own. While institutions have a captive client and surround the client with all the sources necessary to execute treatment, in a community, treatment exists in the form of a stand-alone clinic or individual therapist. For treatment to work, community-based systems need support services. Someone must recognize and identify the problem. Someone must get the client to the clinic. Someone must help the child's family overcome its own dysfunction. And, in many cases, someone must offer parents a break from the stress, teach parenting skills, or offer help obtaining financial resources.

Local professionals almost universally believe residential and home-based models must exist at once, according to our case studies. A 1991 DHS study of providers and agencies corroborated this finding in a draft report which called the RTC vs. community services conflict an "artificial dichotomy" which "fails to recognize the valuable services provided by each." National models of comprehensive children's mental health systems include both components. Notwithstanding, debate continues over the proper balance with most local worker believing that the balance should swing more toward community-based services.

Our case studies indicate a fierce demand for services in all sectors of the children's mental health system, both residential and community-based. The backlog has made it more difficult to place those children who need residential treatment. In several case studies, workers indicated that children who would have been placed in treatment several years ago would take a back seat to more severely disturbed children today. "Ten

years ago, John probably would have been put in a medical or residential treatment facility where he would be having counseling and educational services," a county protection worker said about one case study. "Today, to get kids into residential treatment is extremely difficult."

Interpretation of the demand can be tricky. Because demand for residential treatment continues to be strong, it is common among state administrators to believe that counties prefer residential placement; indeed, as we have documented elsewhere in this report, there are financial incentives for counties to prefer such out-of-home placements. Yet, local workers deny a bias for residential treatment and claim their cries for community-based treatment and support services are equally frantic.

COMPREHENSIVE CHILDREN'S MENTAL HEALTH ACT STRUCTURE AND MANDATES

The basic vision of a service delivery model is not in contention in Minnesota. The Legislature, in 1989, adopted the Comprehensive Children's Mental Health Act that mandates a comprehensive array of services, coordinated across agencies, which is based on the widely-recognized Child Adolescent Service System Program (CASSP) model developed by the National Institute of Mental Health. The Act outlines a system of home and community treatment, along with all the support services necessary to make such non-residential treatment feasible.

Services mandated in each county by the Comprehensive Children's Mental Health Act (M.S. 245.487-.4888) are:

(1) education and prevention service
(2) early identification and intervention
(3) emergency services
(4) outpatient services
(5) family community support services
(6) day treatment
(7) residential treatment
(8) acute care hospital inpatient treatment
(9) screening
(10) case management
(11) therapeutic support of foster care
(12) professional home-based family treatment

The Act also creates the environment within which these services are to function. Although the Department of Human Services is charged with responsibility for implementation, state policy mandates a role in children's mental health for all state agencies that serve children.

Mental Health services must be "coordinated with the range of social and human services provided to children and their families by the departments of education, human services, health, and corrections." Coordination is required at three levels: state agencies; among local agencies; and at the individual case level.

The latter responsibility, coordination at the individual case level, is given to local case managers. They must attempt to gather around the client all of the necessary services -- including mental health services, assessment, and community support services, as well as educational, social, medical, vocational, and recreational services. Plus, they must coordinate

advocacy, transportation, and legal services. All of these things must be coordinated with the client's family.

The system also must "identify and treat the mental health needs in the least restrictive setting appropriate to their needs." This includes providing services to children and their families in the context in which the children live and go to school."

The Act recognizes that funding structures are a crucial component of a workable system and, thus, requires DHS to address "the unique problems of paying for mental health services for children," including public funding and access to private insurance.

However, financing of mental health services is complicated by statutory language which may be contradictory.

The Act specifically ties children's mental health services to the Community Social Services Act (CSSA) block grant fund by requiring counties to plan for these services as a component of the mandated CSSA plans. Counties are, then, required to use CSSA dollars to fund these services [M.S. 245.4874]. While these are a county's most flexible dollars and would be the logical choice for a county committed to children's mental health, the requirement is inconsistent with the intentionally unfettered block grant concept.

Further, despite this requirement and the mandated provision of the full array of services, counties are not required "to fund services beyond the limits of legislative appropriations" [M.S. 245.486]. Several counties have threatened legal action on this basis.

DEVELOPING A COMMON LANGUAGE

Education and human services work with the same children, but one wouldn't know it by listening to them talk. Their distinct purposes have led to development of different terminology.

Human services classifies mental health clients as "emotionally disturbed" (ED) or "severely emotionally disturbed" (SED).

Education categorizes the same children as experiencing emotional or behavioral disorders" (EBD). EBD children are further classified according to the intensity level of the services they receive, from Level I through Level V.

"Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM) or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD); and

(2) seriously limits a child's capacity to function in primary aspects of living such as personal relations, living arrangements, work, school, and recreation.

"Severe emotional disturbance" means

(1) placement or at risk of admission to residential or in-patient treatment;

(2) a Minnesota resident receiving treatment through interstate compact;

(3) determination by a mental health professional that the child has a psychosis or clinical depression, presents a risk of harming self or others or has psychopathological symptoms resulting from abuse or trauma;

(4) has impaired home, school, or community functioning as a result of emotional disturbance.

Level I EBD has the child entirely in the regular classroom. Instruction is provided solely by the regular classroom teacher who consults infrequently with a special education teacher.

Level II EBD differs from Level I only insofar as the regular education teacher consults more frequently with special education personnel.

Level III EBD has the student with the special education teacher less than half time.

Level IV EBD has the child with the special education teacher for as much as three-quarters of the day. Commonly, the setting is the special education "resource room".

Level V EBD has the child full time with the special education teacher. Settings may include self-contained classrooms, day treatment facilities, or alternative schools.

The two schemes roughly correspond this way:

Human Services		Education
ED	is	Level I Level II Level III Level IV
SED	is	Level V

However, this correspondence is controversial. Schools weigh behavioral factors heavily when setting children into the EBD categories. Mental health professionals claim that some children are placed in Level V settings because they are behavioral problems and are not emotionally disturbed.

Conversely, children with severe emotional disturbances may receive lower level EBD services if their disorders do not cause them to disrupt the classroom.

THE SYSTEM IS OVERWHELMED BY SEVERELY DISTURBED CHILDREN

Local workers describe a system besieged by an overwhelming number of children with increasingly severe disturbances.

A metropolitan probation director described his experience with emotionally disturbed children:

"The youngster in Bloomington who killed a woman was actively psychotic but had been terminated for treatment because the insurance ran out after 45 days. There was

the 13 year old who was thrown out of a foreign county because his behavior was so outrageous. He came back and stole half the cars in the neighborhood and burglarized half the houses. He shot a 74 year old woman in the head, stole her car, ended up in a high speed chase. He aimed his car right at the squad car at the road block and gunned it. We filled three rooms in the Grand Forks hospital. He fits the diagnosis of an anti-social personality in every way except that you can't be one of those until you're 18. We have a girl who lived in two worlds. She was a popular, active high school girl in one world. She was a boy in another world and dated as a boy. She's in for sexual misconduct for sexually abusing other girls under the pretense of being a boy. We have an 11-year-old boy who is burning garages in his neighborhood. When he was about six, his father died in a fire. That's the kind of situations that are in our world everyday."

Our case studies illustrate how severe emotional disturbance has spread wider and deeper into the children's population, affecting greater numbers and younger ages. "Five years ago, we were dealing with maybe 15 to 18 year olds. Now we're dealing with 9 and 10 year olds," an outstate juvenile police officer said. "Ten years ago, you never heard of a 9 year old going out and doing burglaries and stealing cars, and thefts, and assaults. Now, it's almost on a weekly basis that we have 9, 10, 11 year olds out doing this stuff."

While the Comprehensive Children's Mental Health Act requires counties to establish services for all emotionally disturbed children, responding to the crises presented by those most severely disturbed children overwhelms most resources, leaving little or nothing for early intervention and the less severely disturbed.

Large numbers of children do not receive mental health services because the disturbances they exhibit are not severe enough to command a high priority.

These are the so-called "at risk" children and they exhibit early signs of emotional or behavioral disturbances which warrant evaluation, according to mental health professionals and educators.

An illustration of this barrier comes from one of the case studies conducted for this analysis. A profile of a 9-year-old child called Tony was presented, including a description of behaviors exhibited in the home and school. According to a psychiatrist attending the study, Tony exhibited signs of pre-psychosis, depression, and separation anxiety which, left unaddressed, could result in "more bizarreness, more aggression, more difficulty on impulse control or isolation". He was "at risk".

Yet, all the local service providers attending the study agreed that a child with such a profile would not receive services in the current system. "This kid would never make the cut for services," a social worker said.

"One of the things I fear when I hear these examples is that we're way too late," a social services supervisor said. "We keep paring down our caseloads to only those families who have children in placement. That's way too far down the line.

The consequences of ignoring "borderline" cases - easy to do because many children outgrow them - can be devastating for the children, the family, and for society. One mother told this story:

"My son started out in the mental health system at age 7. This cute little boy who was supposedly acting strange. When I took him to doctors or took him to other professionals, they would say: 'He'll outgrow it. Boys are a little behind girls. Get him into the Boy Scouts.' I mean I had a lot of concerns. Something as a parent was triggered inside of me that this behavior was not normal; something's strange. You ask parents, when did you first notice there was a problem? They'll tell you six months, a year, two years old. But until the child acts out and becomes dangerous to society, nobody takes you seriously. I now have a 16-year-old who's in jail." In April 1992, her son was released from residential treatment because funding ran out. Several days later, he killed someone and is now in prison on a murder charge.

The cost to society persists for many years, another probation officer said:

"The four year old that we talked about, the fourteen year old, the seventeen year old...those are the future of society. If the money or resources are not put into trying to make them productive members of society, chances are, they are going to be sitting down in Oak Park Heights at $40,000 a year and not producing anything. The revolving door continues in adulthood as it did in adolescence. I'm working with juveniles that we are spending thousands and thousands of dollars on and I don't see the light at the end of the tunnel. These are the people who are going to be using up a lot of the resources instead of contributing to the resources."

In schools, the frequent failure to respond to the early stages of emotional disturbance is the result of the particular pressures schools face.

Educators claim they possess the ability to recognize emotional problems. Yet, they admit there has been a greater tendency to recognize behavioral problems than emotional problems because dysfunctional behavior is easier to spot and has a greater impact on the teacher whose classroom may be disrupted. A suicidal child who is not disruptive, for example, probably would not catch many teachers' attention. The failure, then, is not a failure to see behavior that indicates a problem, but a failure to properly rank its relative importance.

According to a metro-area EBD teacher, schools are beginning to pay closer attention to the "E" in EBD. More teachers have learned to notice subtle signs of possible disturbance. Nevertheless, a quiet emotional disorder would not command the same response as disruptive behavior.

"The problem would be recognized," an elementary school principal said, "but he would not qualify for services. In order to qualify, Tony would need to be having some real severe social issues with his peers and he'd need to have some behaviors that were interfering with his ability to do school work."

Schools are under pressure to keep special

education costs down. "Because of pressures on the schools and on special education to keep costs down, they either don't qualify for special education or they never get assessed until the behavior or the educational process degenerates," a local special education administrator said. "Earlier interventions may have very well have got the kid turned around early on."

Special education teachers and school social workers face unmanageable case loads. Children who are not disruptive and who have passing grades would, at best, be borderline cases. "Kids like Tony, who could really benefit from some early intervention kind of get put on the lower priority because we don't have time to get to them," a social worker said.

In corrections, the story is the same. Children with early signs of trouble are ignored while behavior deteriorates toward the threshold necessary for a intensive response from the system.

A probation officer investigating the history of a juvenile offender often discovers earlier signs of trouble. "By the time I get a child at 13 or 14," one probation officer said, "there are all these red flags and I'm thinking, 'Why didn't somebody notice these red flags? Maybe this child could have had some sort of intervention before he ended up in the corrections system.'"

A child comes into contact with the corrections system for such non-criminal "status offenses" as truancy which were supposedly designed to intercede with children who might be headed toward serious criminal behavior. The law says that a secondary student is truant after missing seven days of school and should receive a citation. In Hennepin County, pressure on juvenile courts is so great that judges have ordered citations not be issued until a student has missed 14 days.

At that point, almost nothing is done. After a second 14 days of missed school, the child is assigned to a case worker who is supposed to monitor the child's compliance with court orders such as to attend school. But case workers in many counties find effective intervention difficult with their large caseloads -- about 150 per worker in Hennepin County.

When a child's condition deteriorates to the point that he begins to break the law, counties are forced by the courts to spend more money on that child than would have been required for early intervention. "For a fraction of that money being spent when this little boy was nine to get the ADHD (attention deficit hyperactivity disorder) assessment or other mental health screening, you could have totally eliminated the need for this," a protection worker said.

Workers suffer frustration when they are unable to intervene when it would do the most good. They find themselves trying to prioritize their cases. "It's triage," said a school social worker, referring to the modern military practice of selecting which war casualties receive medical treatment. "I even prioritized my own case load because I don't have time to get to all the families in the way I want."

THE LIMITS TO WHAT SCHOOLS CAN DO

Once a classroom teacher identifies a potential problem, the ability to respond varies among schools. "Services vary county to county, school district to school district, teacher to teacher," said a northern Minnesota special education director. The variability is a function of resources and staff quality.

A common response, once an emotional problem is suspected, is that the teacher will communicate his or her concerns about the child to a staff specialist, a special needs team, or the school principal. Sometimes, the teacher will first speak to parents in a parent/teacher conference. In other schools, parents will be consulted by specialists or the principal.

Parent's response to the problem is crucial: formal assessment cannot be conducted without parental approval. While some parents are cooperative, others must be "brought along", according to one EBD teacher. Still others adamantly refuse any involvement with mental health or special education.

Parents may be reluctant for several reasons. Many don't want to believe their child has a problem or they are afraid of the stigma attached to "special education". The Hastings school district, and others, approach such parents with great patience, providing evidence and reassurance. Most eventually cooperate.

Parental rights are paramount. Except in an emergency, schools cannot assess or provide mental health services to a child without parental cooperation. Schools may seek "conciliation", a due process step in federal education law; however, the burden of evidence collection and legal fees make this step prohibitive in all but the most extreme cases, local educators say. Even then, the chance of overriding the parents is slim.

Educators have no disagreement with parental preeminence, saying that most parents want what's best for their children. And parents are quick to point out that parents are a more stable presence than teachers who change every year or specialists who have many other children for whom to care.

But those children for whom their parents are the problem -- abuse cases being the primary example -- may need an outsider to intervene in the family. It is these children whom the school may be unable to help.

The next step is assessment. How it's done depends upon the resources available. Many schools have special education staff capable of conducting an assessment; the depth and breadth of that assessment, again, depends on the qualifications of the staff available. Other schools make use of outside consultants. A few have on-staff mental health professionals.

School response to the assessment varies. Our case studies indicate that, while some school staff are sensitive to special education needs, others fail to acknowledge them. One parent of a son with severe attention deficit hyperactive disorder said, "The principal told us what he needed was a good spanking. We have been fighting with the school for five years."

Beyond assessment, the response again depends on resources. Teachers in EBD programs often find that even children who get into their programs are not getting the services they need. "We manage them but we can't fix them," a special education coordinator said. Another said: "We provide the educational programs we can provide but it isn't what that child needs at that point in time. We're doggone high-paid baby sitters for some kids."

Districts with social workers, mental health professionals, or alternative special education programs may actually provide mental health treatment. Others recommend to parents that they contact outside assistance at their own expense.

"We have no control over whether the child receives any counseling," an EBD teacher said. "If their behaviors become so obvious that something needs to be done, we need to go through a long system of documentation before social services can get involved. That is, unless the kid becomes truant. It's quicker that way. Once you can involve the law enforcement aspect, it's faster."

"There are a lot of schools that tend not to want to get too involved in providing special-ed services," a county social services supervisor said. "It's big bucks. Only so much is reimbursed federally and that percentage has diminished over the last five to 10 years."

The intent of special education is not to treat an emotional disturbance but to overcome emotional, behavioral, or developmental obstacles to educational progress. Special education does not have either the responsibility or the authority to address the whole child.

In fact, schools have a good financial reason not to do so. Any service that is formally identified in a child's Individual Education Plan (IEP) as being needed to overcome an educational obstacle becomes the financial responsibility of the school.

"The school will never write on a piece of paper, 'We recommend you get counseling,' because then the school is liable to pay for it," a special education director said. "So a school can suggest to a parent, 'We think you should do this. It would be good for your kid.' But we will never push it past a certain level."

THE IMPACT OF THE JUVENILE JUSTICE SYSTEM

The corrections system is a key actor in the overall system that serves emotionally disturbed children. While its role is not specifically to address mental illness, many children accused of breaking the law are emotionally disturbed. The manner in which the corrections system functions impacts their treatment and their disorders.

The relationship between the corrections and the mental health systems and the number of shared clients is difficult to quantify. Estimates on the number of shared clients range from 10 percent in Department of Corrections facilities to 80 percent of community corrections clients. Anecdotal evidence from our case studies suggest a high correlation between emotional disturbance and juvenile delinquency.

Although much discussion occurs at the local level as to whether a particular child is emotionally disturbed or delinquent, to a significant extent, they are the same children, a county probation director said:

"There is a perception that there are two piles of kids out there, that there is this pile of corrections kids that need to be held accountable and have their behavior managed, and that there is another pile of kids who are mental health kids who need to be treated, who need to be protected. The reality, from my experience, is that about 80 percent of those are the same group of kids. They have a foot in both worlds."

"Over half of our kids in first intake already have histories either in child protection, family services, or children's mental health and over 23 percent have been in out-of-home placement before we get them," said a Hennepin County probation administrator. "So they're not a different group of kids."

Yet the roles that the two systems play in the lives of children is fundamentally different: the mental health system is designed to treat emotional disturbance; the juvenile corrections system is designed to control behavior and hold children accountable.

Forcing the distinction between emotional disturbance and delinquency is a barrier to treating the child's emotional problems, our case studies suggest. "Once they get into the criminal system, they're no longer emotionally disturbed. They're criminals," according to the mother of an emotionally disturbed adolescent who has been jailed.

Debate on this issue frequently is played out in the schools which must determine how they are going to handle particular children. The vehicle for making the distinction between emotional disturbance and delinquency traditionally has been the mental health (DSM-3) label: "conduct disordered", used by some schools to el those children thought to be beyond the capability of their EBD programs. (Conduct Disorder is further discussed in Section IV. of this report.)

The tendency to force an artificial distinction between emotional disturbance and delinquency may have financial motivations: the label determines which agency must serve these most troublesome youth.

But local workers say the mental health and corrections systems are beginning to talk about the mental health needs of children who have broken the law. Juvenile corrections clients sometimes are being referred back to mental health agencies. And in some counties, protection workers also serve as probation officers.

"We're looking at delinquency that is relatively minor and clearly is related to the same issues (that mental health or social workers have dealt with)," a probation director said. "It makes absolutely no sense to change systems, to change workers, to change everything on that child at that point simply because now he has broken into a house and been charged with burglary. We're beginning take these kids who have histories with social services and make joint decisions on which system is going to care for the child."

While such joint responsibility and coordination is a step in the right direction, local workers say that joint facilities are needed: "What we need in the system is facilities that can do both control behavior and treat mental illness," a probation officer said. "The first thing is that has to happen here is that we have to protect the rest of the community and other children in that setting from this kid. So the first issue is behavior management. Now underlying all this behavior, something is going on with this child. It doesn't do a whole lot of good to just manage this kid's behavior for six months and then turn him loose."

Local probation officers have long recognized the inflexibility of their system and have sought ways around it: "What has traditionally happened," a probation officer said, "is that we got a kid at 13 for stealing cars and, even though he's never stolen another car, we have kept that kid on an open probation case until he's 18; not for any corrections reasons but to provide services."

This practice provides a partial explanation of court-ordered social services expenditures. When a probation officer includes recommendations for mental health or social services in a child's disposition plan, judges usually order the recommended services and order county social services agencies to pay for them. "In a lot of cases, it's the only way you're going to get him service," another probation officer said.

Emotionally disturbed corrections clients sometimes are victims of a characteristic of the court system that, ironically, is designed to protect their rights: the adversarial nature of judicial proceedings. Probation officers, acting as officers of the court, frequently recommend that a judge order treatment for emotional or behavioral disorders. But, from the point-of-view of children's attorneys, court orders -- especially residential treatment that restricts a child's freedom -- look like punishment and it is their job to mitigate consequences for their clients.

"They're going to argue very eloquently before the court that this is a miscarriage of justice because this child, after all, only stole $35 worth of stuff," a probation officer said. "So we have the poor judge trying to balance the valid part of that argument versus the needs of the child. What happens is that he comes up with three weeks of treatment which makes no sense at all to the needs of the kid but it was sort of between the two positions. So the court creates a disposition that doesn't satisfy anybody."

THE TRANSITION TO A COMMUNITY-BASED SYSTEM

Minnesota is in a transition phase: it is trying to sustain the infrastructure and operational habits of an institution-based system, while it tries to convert to a community-based system.

That more community-based services should be developed and be made available to more children is not in contention. Instead, debate seems to focus on the somewhat subtle question of balance: how much of the state's resources should be allocated to residential versus community-based services?

Most local professionals and state supervisors agree that some of the children currently receiving residential and acute care treatment could be shifted to care in a community-based system if sufficient treatment, support services, and case management services were developed. And most professionals agree that a predominantly community-based system will be cheaper in the long run, at least if resources are focused on finding and treating disturbances early, before they reach a crisis threshold.

None but the most ardent opponents of residential treatment want it eliminated altogether. Local professionals, without exception during our case studies, envisioned a continuing role for residential treatment for the most severely disturbed or dangerous children and adolescents.

Transitions put extraordinary demands on resources and can be approached in several ways. One way is to simply reallocate existing resources from residential treatment to community-based services. It is difficult to envision, however, what would happen to those severely disturbed children in residential treatment who would be suddenly cut off of services.

Second, the state could infuse massive, but temporary, amounts of new money into children's mental health to establish new community-based and support services while simultaneously operating a residential system until such time as most clients are transferred from residential to non-residential care. A slower approach could trickle new dollars into the system with a correspondingly longer transition period and, probably, greater long-term cost.

A third option might be to redesign the system from the ground up in order to make it both more therapeutically effective and fiscally efficient. New dollars committed to a more efficient system would have greater impact.

Service Coordination

Minnesota's community-based system is disjointed. It consists of far-flung, independent service providers who were trained into distinct disciplines, who function according to dissimilar models, and who serve different organizations, each of which must answer to an independent state agency. Services have developed piecemeal in some communities and not all in others.

Such a system faces an inherent obstacle: In order to bring its resources to bear on any single client, it must coordinate the disarray.

The Comprehensive Children's Mental Health Act mandates interagency coordination at three levels: the local agency level, the state agency level, and the individual case level.

Our case studies provide anecdotal evidence that interagency coordination of services at the case level is widespread in local communities. Most of it seems to be informal, taking the form interpersonal relationships developed and nurtured over years of effort. It is, however, inconsistent. Some communities have extensive networks involving most service providers; other communities have virtually no coordination, blocked by attitudes of aloofness and competitiveness or concerns about confidentiality.

Local workers indicate that informal contact among agencies is most commonplace among schools, county social services, and probation officers. Some communities work closely with residential facilities. "At times we have a very good working relationship," a protection worker said about her network. "It depends somewhat on personalities."

State agency coordination is the responsibility of the Interagency Coordinating Council, established by the Act to include representatives of the human services, education, health, corrections, and commerce departments plus members from the Office of Strategic and Long Range Planning (formerly the state planning agency) and the district judges association juvenile committee. The council must:

(1) educate other agencies
(2) develop interagency coordination
(3) identify service delivery barriers
(4) recommend policy and procedural changes
(5) identify funding improvements

This final duty - to identify mechanisms for better use of funds - will fall to the Mental Health for Children Task Force, established by DHS in response to the 1991 Legislature.

Among the Council's efforts to coordinate state-level activity was a 1991 move to write an **interagency agreement** for state agencies in order to assist with the development and delivery of a unified, accountable, and comprehensive mental health service system. The purposes of this agreement are:

(1) To clarify the mission and goals of the collaborative interagency effort to carry out the provisions of the Children's Mental Health Act and complementary policies of the various agencies;

(2) To define individual and joint responsibilities of the agencies to attain those goals;

(3) Establish a process to develop annual objectives for state agencies to ensure that the statutory mission and goals are carried out by the agencies.

Local agency coordination is the responsibility of Local Coordinating Councils in each county, according to the Act. Mental health, social services, education, health, corrections, and vocational services must be represented. Their duties include:

(1) drafting interagency agreements to coordinate services to children;

(2) estimate unmet needs;

(3) report to the Local Advisory Councils and county boards with a description of services, funding sources, expenditures, and the numbers and characteristics of children served.

In a related manner, the Act requires counties to establish Local Advisory Councils to:

(1) seek input from parents, former consumers, and providers about the needs of emotionally disturbed children;

(2) evaluate and make recommendations on the local system;

(3) report on the unmet needs of children.

However, formal interagency cooperation is not occurring at the local level. A 1991 survey of local coordinating councils by the Department of Human Services showed that most local coordinating councils had not established the required protocols and procedures. Survey results also indicated that the type of formal relationships necessary for interagency collaboration are in the earliest stages of development in most communities.

Surveys indicated that local coordinating councils were frustrated by the lack of any joint money authority which would allow agencies to share funds or distribute service costs.

The local coordinating councils, according to the surveys, are most beneficial when they enhance informal relationships among local agencies and enhance professionals' abilities to act. The aspects which local agencies perceive as least beneficial are those functions that promote formal, institutional relationships among agencies. These findings are consistent with evidence gathered for our case studies which suggests that local agencies find their own initiatives toward interagency coordination to be more beneficial than state-mandated coordination procedures.

For a complete report on the survey and its findings, see Appendix A.

Individual case coordination is the responsibility of the local case manager, according to the Act. All severely emotionally disturbed children and their

families must be provided with case managers by April 1, 1992. [MS 245.4881]

The case manager must coordinate the planning, development, and delivery of services to the child by social services, education, corrections, health, and vocational agencies. This coordination must be reflected in a "family community support plan".

Local workers acknowledge that his concept -- what they call the "strong case manager" model -- has some credence. Yet they have reservations.

"A case manager under those conditions really needs to get a lot of support and training," said a mental health center director. "If we're going to use the strong case manager model, we've got to treat that person as a genuine professional who really needs some competence and knowledge, not just a job title."

Case management can't work well unless much of the bureaucratic burden is removed, a social services director said. "The way it's been developed in Minnesota through the MR Waiver is that it's become so complex that you're going all the way to the state to get things approved. If we're moving to case management, let's have a system that's relatively simple to give a person a chance to be out meeting with the people. They just haven't had a chance to get to know the people they're working with."

Data Sharing And Integration Of Information Systems

Information systems along with the service delivery system and funding structure are the three primary components of an integrated children's mental health strategy.

Programs require information. Decisions and choices on how to spend money, what services to create, what clients to support all require accurate and reliable information. Without information, decisions are, at best, political.

Currently, accurate data on services provided to emotionally disturbed children is difficult to obtain. The local and state agencies which provide services and administer funds vary widely in their abilities to collect information. No interagency data sharing mechanism exists which would provide information on all the services received by an emotionally disturbed child.

In order to understand what is actually happening in a delivery system there are some basic information requirements which must be met. These basic questions include: Who is getting how much of what services? How much do they cost? Who pays?.

Counties are responsible for social services data at the local level. At the high end of data capabilities are the systems in Hennepin and St. Louis counties whose comprehensiveness, detail, and accuracy exceeds that of state systems. At the other end are systems which produce virtual fantasy.

At the state level, capabilities again vary widely. The Department of Human Services collects great detail on medical programs such as Medical Assistance and General Assistance Medical Care which are large contributors to mental health services. Until recently, very little information was available on social service programs -- which include much of mental health. Social services fiscal and client data which can be clearly identified for children's mental health services will become available for reporting effective January 1992. Even this innovation will not tie community-based services information to MA/GAMC data on a client-specific basis.

DHS has made significant improvements in recent years in the information available about human services expenditures for children's mental health. The Community Mental Health Reporting System provides client specific data. The BRASS taxonomy and its application to all county social service activities now provides specific expenditures, sources of funds, and units of service. DHS staff have been working to integrate these and other sources of information in order to be able to follow clients over time and develop a complete picture of children's mental health provided through the human services system.

The Department of Education can produce expenditure, revenue, and client data in great detail.

The Department of Jobs and Training began,

for 1991 data, to distinguish emotionally handicapped clients from those with physical and mental handicaps. This improvement is for its Youth Employment and Training programs only. Other DJT programs cannot distinguish the emotionally handicapped from other clients. Nor can they distinguish adolescent from adult clients.

The Department of Corrections has almost no capability to provide information on clients with emotional disorders. Local corrections data, even in counties with sophisticated information systems, is less illuminating than in other areas.

The lack of information contributes to fragmentation of funding sources and delivery systems. When a need for services for a specific problem is identified but information about current activity is unavailable, the tendency of interest groups and legislators is to create a new program. This allows them to target dollars. However, along with the new program come new rules, new requests for proposals, new applications, new review committees, new fiscal and program reports, and new service providers. The end result is less integration and more administration.

The process is like filling potholes. A hole in the system is identified and a program is created to fill it. A patchwork develops.

All of this activity is a substitute for having a comprehensive picture of what is happening and how it is changing in response to changing needs. Integration of funding and services, at least in the long haul, is dependent upon reliable and timely information.

The state has only begun to look at interagency information needs. A comprehensive information system must include at least human services, education, and corrections activity. It is not clear that the results would be worth the effort required. Ultimately, effective coordination and integrated services must be accomplished locally, and no amount of interagency information sharing at the state level will bring that about.

IV.

BARRIERS
TO AN EFFECTIVE, EFFICIENT SYSTEM

Many barriers exist to the establishment of an effective and efficient children's mental health treatment system with a full continuum of services as mandated by state policy in the Comprehensive Children's Mental Health Act. The barriers described below were identified through a combined analysis of statistical data, recent state and national literature, and anecdotal evidence obtained through case studies with local treatment providers, social workers, educators, probation and law enforcement officers, public health nurses, employment staff, and parents of emotionally disturbed children.

Funding Levels Are Inadequate

A shortage of dollars is the primary barrier to improving the effectiveness of the children's mental health system; this is the one claim that receives almost universal agreement among professionals and administrators in the system.

It usually is defined as a shortage of dollars needed to establish the home and community-based services lacking in most communities and, thus, make the transition in Minnesota to a home based treatment system which would provide more effective treatment and save public dollars in the long run.

Elsewhere in this report, we discuss an approach to making this transition that would not require a substantial influx of new dollars: reallocation of current funds from residential treatment to home and community-based services. That begs two questions: First, how does the system treat severely disturbed children while new services are being established? Second, what services would a wholly home-based system provide to those children who were not identified early and are already severely disturbed?

The response from local workers is that such a reallocation of funds away from expensive interventions in order to create a more effective and less expensive system would wreak havoc on a generation of severely disturbed children and, ultimately, cost society more in both dollars and danger.

Dakota County's experience is indicative. In the mid-1980s, when the county was experiencing a population boom that sent demand for social services skyrocketing, a decision was made to cut off treatment to severely disturbed 17 and 18-year-old adolescents. "Now we're getting them back

1989 CHILDREN'S COMPREHENSIVE MENTAL HEALTH ACT, INCL. 1991 AMENDMENTS

	NEW FUNDS NEEDED EXCLUDING APPROVED BUDGET BASE				
	FY91	FY92	FY93	FY94	FY95
EARLY IDENTIFICATION AND INTERVENTION	$0	$0	$0	$200,000	$300,000
OUTPATIENT					
OUTPATIENT-CHILD'S HEALTH PLAN	$0	$0	$833,267	$999,920	$1,183,239
CASE MANAGEMENT-(MA/SPMI)	$0	$0	$0	$0	$0
CASE MANAGEMENT-(MA/SED)	$0	$0	$0	$0	$0
CASE MANAGEMENT-(NON-MA)	$0	$0	$844,043	$1,263,766	$1,376,955
CASE MANAGEMENT SUB-TOTAL	$0	$0	$844,043	$1,263,766	$1,376,955
PROFESSIONAL HOME-BASED(MA)	$0	$0	$0	$0	$0
PROFESSIONAL HOME-BASED(NON-MA)	$0	$0	$2,070,041	$3,693,832	$5,128,492
PROFESSIONAL HOME-BASED SUB-TOTAL	$0	$0	$2,070,041	$3,693,832	$5,128,492
THER. SUPPORT FOR FOSTER CARE:					
REGULAR MA	$0	$0	$0	$0	$0
NON-MA	$0	$0	$576,700	$1,835,000	$1,926,750
THER. SUPPORT / FOSTER CARE SUB-TOTAL	$0	$0	$576,700	$1,835,000	$1,926,750
DAY TREATMENT-(MA)	$0	$0	$0	$0	$0
DAY TREATMENT-(NON-MA)	$0	$0	$25,148	$352,159	$393,367
DAY TREATMENT SUB-TOTAL	$0	$0	$25,148	$352,159	$393,367
OTHER FAMILY COMMUNITY SUPPORT SERVICES-(MA-REHAB)	$0	$0	$0	$0	$0
OTHER FAMILY COMMUNITY SUPPORT SERVICES-(NON-MA)	$0	$0	$952,848	$2,821,478	$0 $3,056,952
OTHER FCSS SUB-TOTAL	$0	$0	$952,848	$2,821,478	$3,056,952
SCREENING-COUNTY(CSSA)	$0	$0	$0	$0	$0
SCREENING-MA	$0	$0	$0	$0	$0
SUB-TOTAL (MA-REHAB)	$0	$0	$0	$0	$0
SUB-TOTAL (MA)	$0	$0	$0	$0	$0
SUB-TOTAL (NON-MA)	$0	$0	$5,302,048	$11,166,156	$13,365,755
STATE ADMINISTRATION	$0	$0	$125,000	$148,750	$173,688
TOTAL	$0	$0	$5,427,048	$11,314,906	$13,539,442

Figure 12

at age 22 in adult corrections," said a family services administrator. "They survive for awhile but they end up homeless or drug dependent." The same decision is responsible, she said for a major shift in the county's vulnerable adult population from elderly and developmentally disabled to young adults.

The lesson indicated is that the state cannot afford to cut off residential services in order to establish early intervention and non-residential services even though residential services now absorb most of the system's resources. Thus, new dollars are needed.

It is important to quantify new resources required. One indicator is the deficiency of dollars appropriated for full implementation of the Comprehensive Children's Mental Health Act the purpose of which is to establish a full continuum of home and community-based services in every Minnesota county. Projections by the DHS Mental Health Division show that state appropriations will be $5.4 million short for FY 1993 and climb to a $13.5 million deficiency by 1995, as shown by Figure 12.

Funding Structure Is A Barrier To Recreating A Better System

The funding structure of the existing children's mental health system inhibits the efficient flow of dollars to the services needed by emotionally disturbed children.

Inefficiency does more than make services more costly. By diverting the flow of scarce resources away from some of the clients who need services, the funding structure actually prevents the system from doing what it is intended to do.

The elements of the funding structure which make it inefficient are described in Section III under "Funding Structures." As described in that section, the funding structure does not block the establishment of needed services, but it does block many needy children from receiving those services.

"Least Restrictive Setting" Mandate Limits Treatment Options

Minnesota's Comprehensive Children's Mental Health Act mandates that services to emotionally disturbed children be provided in the "least restrictive setting appropriate to their needs". Federal education laws (specifically, P.L. 94-142) contain similar language.

It is a philosophy that has been widely adopted because it is thought to provide more effective treatment and, by reducing use of residential services, it is cheaper.

Many county social service agencies and juvenile courts have interpreted the language and the philosophy to mean that each child's treatment must begin at the lowest level and progress, step by step, into more intensive treatment.

The problem, according to our case studies, is that many children already need more intensive intervention by the time their problems come to light. The result of having to try the least restrictive interventions

before obtaining more intensive services is that treatment is always a step or two behind their advancing illnesses. A child is forced to fail at one level of treatment before he is permitted to receive the level of treatment that would be most effective.

The need for this step-by-step progression of services is not specified in state children's mental health law and it is questionable that federal education law includes such a mandate. In addition, some county social service agencies and local school districts interpret the language more flexibly to allow whatever level of treatment is necessary as long as less restrictive options have been considered. The Department of Human Services has not clarified the interpretation.

Nevertheless, local administrative policy and judicial practice in many communities makes the step-by-step progression an effective mandate for the professionals who make the everyday decisions about a child's services.

It is common that social services and protection workers, EBD teachers, and juvenile probation officers are required, either by their own agencies or the courts, to attempt home-based or classroom-based intervention first. Failed interventions must be extensively documented before authorization is granted for out-of-home placements or special educational instruction outside the regular classroom.

"You need to prove to the court," a northern county protection worker said, "that you've tried out-patient counseling, in-home counseling, family treatment, parenting skills." Corrections workers say that a child's behavior must be extreme before a judge will consider ordering mental health placement. A 10 to 14-year-old must exhibit out-of-control behavior and be truant for six-months to a year before many judges will consider placement.

The director of a Rule 5 residential facility participating in case studies said: "In the majority of cases that finally end up being referred to a residential setting, we see a consistent pattern that the child has failed at many different lesser-restrictive levels before they come to us. The school says: 'I believe, based on what I know about this child and family, that this child needs to be in a residential facility.' But, because that child has not failed at lesser-restrictive levels, you can't have it. That's a significant flaw in our state system: it's based on failure."

"It's not individualized," he said. "The assumption is that the lesser restrictive is better and, in some cases, that is absolutely not true."

Mandated Coordination Diverts Resources From Local Efforts

Legislatively-mandated mechanisms for local service coordination frequently divert resources away from more effective local efforts. Such mandated functions as local coordinating councils, local advisory councils, placement teams, and protection teams duplicate efforts and produce sometimes questionable results.

Informal interagency networks in many communities function to coordinate services around individual clients and, in this sense,

serve the function of a case manager as mandated in the Comprehensive Children's Mental Health Act. Additionally, although these networks do not operate according to formal interagency protocols, they do serve to coordinate responsibilities across agencies.

Local workers who participated in our case studies championed coordination of client services across agencies. But they view state efforts to force coordination as another bureaucratic hurdle that diverts their attention from their clients. Estimates of professional staff time spent meeting in mandated groups go as high as 50 percent.

Local workers claim that their informal networks work better than the formalized meetings of the mandated coordinating and advisory councils and teams. Collaboration among workers in various agencies who are already working with a child is more efficient and effective than discussion of a case by a fixed committee of professionals, advocates, and parents who are not directly involved.

"I ask myself what leads to people being healthy. Usually it means there's an individual who kind of likes you, who works with you, and gets you plugged into people," a Southwest Minnesota social services director said. "I don't know if I've seen a lot of good stuff come out of big committee meetings."

Mandated coordination forces professional staff to attend multiple meetings where they see the same people and discuss the different needs of the same clients.

"We're trying to get the key people," the social services director said. "But, frankly, a lot of these people are the same people you see at child protection teams, at the early help... or the transition teams; the same people you're seeing all the time, anyway. The kids aren't any different. You have to remind people which of the committees they're there for. And, by the time you staff four or five children's committees, you start wearing real thin on viable candidates."

A rural probation officer agreed: "I keep arguing with our social services supervisor because he wants to have a pre-placement screening team. I keep saying, 'Why? We talk to each other all the time the way it is. It just doesn't seem to make sense, but it would appease somebody at the Legislature who thinks that's the way to save more money on out-of-home placements."

Workers believe there is bureaucratic resistance to collaboration at the administrative level. "Coordination implies that somebody's making decisions regarding priorities," a supervisor said. "And when you have corrections, social services, parents, and education together I'm not sure any one of those is willing to allow the other to tell them what to do."

One social services administrator said his county had combined the LCC and LAC. "I know it's illegal, but we're putting together the coordinating and advisory councils until there's a need to separate them."

Where informal networks exist, they are effective. But such networks do not exist in

all counties. Personalities and personal relationships play major roles. Local workers are sympathetic with legislators' desire to compel less-effective communities. But effective communication occurs among professionals who feel a common interest. It can't be mandated from the state Capitol.

"I'm not sure the legislature can create a community movement," a mental health center director said. "It's sort of like an order to be spontaneous."

Despite their dislike of the overlapping coordinating councils, local workers are skeptical that combining them would be politically feasible. "The state would have to make a decision that they're not going to bow to all the little advocacy groups who want to dictate what that committee is going to be," a social services supervisor said.

Coordination of one important variety is outside the realm of local agencies. Local workers in all agencies must match clients who have various eligibility characteristics to funds with various eligibility criteria to available services and then to providers who can both serve that client and receive those funds. Eliminating those complexities of funding structure and eligibility criteria is a function that must occur at the state and federal levels.

Ultimately, the problem might be one of overall administrative structure, not coordination. Currently, the local agencies and state supervisory departments exist in such a way that a client normally must travel to several agencies in order to obtain needed services. No one of those agencies has responsibility for the client's overall needs.

State Agencies' Missions Are Narrowly Defined

State level coordination is stymied by the narrow definition of each agency's mission. For the most part, state agencies supervise funds and, sometimes, programs which are administered at the local level. A growing number of state agency staff are aware that their various funds and programs are merely components of the overall assistance provided to an individual client. But this perception has yet to permeate the agencies or reach the list of top priorities.

The differences among the various agencies' missions toward emotionally disturbed children are subtle but instructive:

The mission of the Department of Human Services is to provide treatment for emotional disturbance. Only DHS is charged with implementation of the Comprehensive Children's Mental Health Act.

The Department of Education is concerned with educating children, including overcoming the educational barriers thrown up by emotional disturbance. Schools also facilitate the child's transition to the community following completion of secondary school. Education is not directly responsible for treating the emotional disturbance itself.

The Department of Corrections is concerned with rehabilitating and controlling juvenile

delinquents even though it understands that many of its clients are motivated by emotional disturbances.

The Department of Jobs and Training wants to help older adolescents obtain productive employment and administers special programs for emotionally and mentally handicapped youth.

The Department of Health wants to identify and intervene in children's developmental delays and assist young mothers who are having trouble nurturing their new babies. These maladies often are manifested in emotional disturbances and mental illness.

Coordination/Advisory Bodies Have not Coordinated Their Efforts

Numerous groups exist at both state and local levels to coordinate programs and services in the children's mental health system. Ironically, their assignments often overlap and these coordinating bodies have not coordinated their own efforts. No focal point of leadership exists. Most were fashioned around a particular problem or to satisfy a narrow goal. Most were set up with independent identities by legislative or executive mandate with no thought to combining forces or eliminating duplicative efforts. Groups known to be involved include:

State Level Interagency Coordinating Committees:

- State Advisory Council On Mental Health
- The Sub-Committee On Children's Mental Health
- State Interagency Coordinating Council (All children ED & SED)
- State Interagency Coordinating Council (Young children with disabilities birth through two years of age)
- State Transition Interagency Committee (Disabled youth, beginning at grade nine or age equivalent)

Local Level Interagency Coordinating Committees:

- Local Advisory Council
- Local Coordinating Council
- Child Protection Teams
- Interagency Early Intervention Committees
- Community Transition Interagency Committees

Appendix B contains matrixes of these coordinating committees which show each group's mission statement or purpose, responsibilities, committee membership, target population, and statutory references.

The purpose of the matrixes is to offer a framework for thinking about service delivery through interagency initiatives and to stimulate discussion by raising some central questions. It does not provide a comprehensive account of what we know or how we ought to proceed. However, this

initial review begs some important questions?

1) Does each committee at the local and state level have distinctly different missions?

2) How are the responsibilities of the local and state level committees the same?

3) Are the same service providers, advocates, and parents required to be members for all of the interagency coordinating committees?

4) Is there duplication in the targeted population to be served? Are several committees dealing with the same children and families?

This report does not assume that coordination in itself is a good or that it is sufficient for successful community-based service delivery to children and their families. The answers to these questions may encourage agency administrators and public officials to act on their experience; these people are unlikely to be interested in coordination for its own sake.

The Fragmented Delivery System Creates Inflexibility

While the total system encompasses a wide array of service options and resources, the fragmentation of the service delivery system means that many of those resources are out of reach of any individual worker.

The helping professional is constricted by the narrow role of his or her agency in the overall scheme of children's mental health. The professional is constricted, further, by the narrowly defined skills and vision of his or her professional discipline. Thus, the options that any single professional has at his or her finger tips are limited and inflexible.

Each agency does only what it knows how to do and there is no single player in the system who has the responsibility or the authority to address a client's needs as a whole.

The administrative rules under which each branch of the system must operate further tie a professional's hands. The authority vested in one helping professional is off limits to another.

Many children served by county social service agencies require both mental health services and child welfare or protection services. A worker helping a SED child who is at risk of placement due to abuse must juggle two completely different sets of regulations. Case documentation and service mandates, such as frequency of client contact, are inconsistent. Personnel qualifications for serving a child through the two systems often are incompatible.

This barrier was illustrated during our case studies. A family services worker in one metro county had been authorizing family community support services (FCSS) to children diagnosed as SED who were on the child protection caseload. But the worker had not been under clinical supervision while coordinating the mental health services. Thus, her actions were illegal.

Local workers realize the mandated standards are "good case practice," according to an administrator from that county. But the inconsistent standards create complexity and great staff frustration. Plus, they often force a county to chose whether it will obey the law or serve its clients as best it can with its resources.

State Family Preservation Policy Is Inflexible

While a solid family is the best environment for a troubled child, local workers say, inflexible state policy pressing local agencies to preserve or reunite families encourages workers to return children to unhealthy environments and, additionally, wastes resources.

State programs evaluate agencies on the basis of their success at keeping families together and reuniting children who are in placement. It is a policy goal with two noble intentions. First, it seeks to focus public resources on strengthening families. Second, it seeks to save money by avoiding expensive out-of-home placements.

But the across-the-board preference for reunification ignores the unique nature of a particular situation. "I think home-based treatment works," said a Rule 5 facility administrator. "But I dislike the idea that we measure the success of in-home treatment on whether a child gets placed out of the home. So what if a child gets placed out of the home for a short period of time and then gets reintegrated, if that's what's needed?"

An out-state protection worker agreed: "There are many times when reunification is not a realistic goal and we need the ability to take kids out."

Nevertheless, workers are pressured to unite families because the evaluations of their programs are based on avoiding placements. "The state says, 'If you do that (place a child out of the home), that's going to be a mark against you and your credibility,'" the Rule 5 administrator said.

The reunification goal also has the effect of wasting money on families with poor prognoses of ever becoming healthy environments. "I work hard to get children the services they need," said a frustrated outstate EBD teacher. "Special education in the school; get them removed from the home; counseling. The kid does well and everything is looking bright and, then, our overall goal is to put that child back into that inadequate home. It happens again, and again, and again, and again. I get damn sick and tired of paying for all these services to be poured down a rat hole. And many of those homes and those families are rat holes."

Local family and protection workers who are afraid to return a child to a dangerous or unhealthy home, but who cannot find a permanent substitute home, are forced to ignore state family preservation law. According to a 1989 Department of Human Services study, nearly one-third of children with open social service cases were in long-term, temporary substitute care placement, a type of setting that is outside of state law.

Schools Must Solve Mental Health Problems With Education Tools

Federal law forces schools to address the mental health needs of their students to the degree necessary to ensure they receive an education. Experience indicates that it doesn't require a major emotional problem to block educational advancement, so educators find themselves trying to cope with a wide variety of problems that are not only beyond the scope of their personal training but outside the parameters of the education model around which their system is constructed.

Education has responded by creating a profession of special education teachers and schools import mental health professionals and social workers. But schools possess varying resources and the services available are inconsistent from district to district.

"But the schools can only bring certain services to bear," an EBD teacher said. "Schools can, and I think schools are good at, making legitimate recommendations to families: 'We think you need some outside help.' Clearly schools aren't trained or geared to deal with these kinds of mental health issues. We are good at saying, 'These are the limits to our expertise, we feel you need to go beyond,' but that's all we can say."

Since schools have the greatest access to the most children, they are, logically, the first line of response to a child's emotional problem. But schools have a financial incentive to ignore emotional disturbances: if they identify a problem, they must address it with their own resources.

Seriously Ill Clients Use Most Of The Resources

Professionals believe that a small number of the severely disturbed clients absorb most of the resources available to the system. First, these children and adolescents tend to be in residential or correctional placement, which is far more costly than in-home and outpatient treatment. Second, these are the people who, having failed previously, come back into the system many times to use still more resources.

But local professionals won't say with any certainty that increased funding flexibility would solve this problem. Even if they were permitted to divert resources from these clients to those needing early intervention, it is clear that society would not tolerate a system which ignored very ill children or turned seriously-disturbed and, often, dangerous adolescents loose on the streets.

Services And Qualified Professionals Are Not Available

Children's mental health services are not sufficiently available in either metropolitan or outstate communities as required by law. Our case studies as well as other recent research shows shortages of two types. First, programs and services, themselves, have not been sufficiently developed in most communities. Second, mental health professionals qualified to provide the services are also in short supply.

If a full continuum of services is not available in a community, many clients will receive an inappropriate service. "What you

find is that you have bits and pieces," a local worker said. "And, like the old adage, if the only tool you have is a hammer then every problem becomes a nail."

"We don't have a day treatment program in this area," another said. "That results in more kids being placed in out of home placements for residential treatment when some of those kids could have been treated in day treatment."

According to surveys completed in the last couple of years, mandated community-based services are altogether absent in many outstate communities. In metropolitan communities, the full continuum of services is more likely to be available but, frequently, not in the quantity necessary to meet the need.

Surveys indicate that services mandated by the Comprehensive Children's Mental Health Act are more likely to be available than non-mandatory services.

Still, the availability of prevention and early intervention services are in critically short supply, according to recent surveys and our research. Such services are considered the backbone of a home and community-based system. Professionals consider early treatment of emotional disorders to be the most beneficial for the client and the most cost-effective. "What happens with early intervention is that there are no services to refer them to," a metro county social services manager said.

The shortage of community services and case management will be mitigated somewhat with the wider availability of the Children's Community-Based Mental Health Services grants. But county administrators say the funds still cannot satisfy the demand. "We could have used four times the money for each of the services to build what we need," a Dakota County administrator said. "We just build them a little at a time."

Support services also are in short supply. County directors, in a 1989 Department of Human services survey, expressed a need for more non-mental health services to support the mental health treatment of children. At the top of their lists were: volunteer programs, parent support groups, specialized day care, family foster care, correctional foster homes, vocational skills training, respite care, and transportation.

It is not just the community-based services that go wanting. Some communities face a shortage of residential treatment beds to handle their demands. Suburban Twin Cities counties, which had relied on the availability of Rule 5 beds in Hennepin and Ramsey counties, have been forced to scramble for alternatives as demand within the two biggest counties increased.

In addition to the lack of services, there is a shortage of qualified providers. The leading conclusion of a 1991 DHS study of mental health providers was that the children's mental health system needs "more and better qualified staff".

Providers said day treatment programs and mental health centers were inadequately staffed. The geographical distribution of child psychiatrists is skewed. There is an overall lack of minority and male mental health professionals to meet the needs of the

changing population of emotional disturbed children.

Providers also said, consistently, that training for existing staff is inadequate: "Most respondents felt that their staff was not keeping abreast of current trends in mental health," stated a draft report on the study. "The bottom line is that quality of care for clients is compromised."

Problems Are Not Identified Early

The mental health treatment system relies on others to identify clients; usually social services agencies and schools. Staff demands are so heavy, only the most severe cases elicit a response.

Thus, by the time the system identifies a child with an emotional disturbance, it often is too late for in-home or community-based treatment and the child then requires a more restrictive and more costly level of care.

Local Workers' Decision-making Authority is Insufficient

The local worker is forced to juggle an unmanageable mélange of client needs, agency procedures, mandates, and resource limitations without sufficient authority to fabricate a solution. State policy is shifting toward "outcome evaluation" for children's mental health, i.e. demanding results instead of conformance with a pre-set process. But local decision-makers don't have enough control to achieve the performance standards that may soon be expected of them. A county case worker said:

"One hindrance to efficient team planning is, for example, if we were here together talking about a common case, who's going to pick up the check. I would bet that most of the people at the table would probably have to go and have another little team meeting back at their agencies to determine whether the input that they had at the meeting was ok, and whether they can put up the check. So there are two agendas going on at most planning sessions: the needs of the kid and then the internal agency decision making mechanism that everyone has to answer to."

The problem is widespread and widely recognized. A paper presented to a 1990 University of Kansas social policy conference stated: "Transforming the mainstream service systems to support services with attributes more supportive of families will require substantially expanded decision-making authority at the local, community, neighborhood, and family level."

Case Management Is Not Sufficiently Developed

Case managers are the critical component of a coordinated service delivery system, bringing the resources of numerous agencies to bear on a client's problem. But case management is non-existent in many counties, leaving parents with the responsibility of trying to pull together a network of assistance for their children.

In addition, case management is undeveloped as a profession. While the Comprehensive Children's Mental Health

Act provides minimum qualifications for case managers, staff come into their jobs only with specialized training in their traditionally narrow disciplines. They have no training in the creative art of fabricating treatment solutions out of the disarray that faces them.

"If we're going to use a strong case manager model we've got to treat that person as a genuine professional who really needs competence and knowledge, not just a job title," a social services supervisor said. "A case manager who has the authority to make decisions as well as coordinate services really needs a lot of support and training. The case manager is not an expert but is fairly well able to ask appropriate questions and understand the answers. All of this is necessary if they're really expected to go head-to-head with judges and mental health professionals and so forth."

The Conduct Disorder Label Is Used To Exclude Children

Our case studies suggest that the diagnosis of "conduct disorder" has the effect of legitimizing an untenable distinction between an emotionally disturbed child and a delinquent child, making access to mental health services difficult.

Although, Conduct Disorder is a medical (DSM-3) diagnosis and properly must be made by a mental health professional, unqualified individuals sometimes apply the label.

"Once that label gets laid on a kid, that pretty much shuts down access to the mental health system for the kid," a metropolitan probation officer said. "Somebody has now said this is a kid whose behavior we need to manage, we need to punish, we need to hold accountable, that we no longer need to treat. This is no longer a sick kid; this is now a bad kid. All of the structures, all of the rules that are theoretically there for protection start becoming obstacles to getting kids into the appropriate level of care. My sense is that it gets the mental health system off the hook. They don't have to deal with the youngster."

Historically, schools have used the label to exclude highly troublesome children. Once the label is attached to a child, or a child is understood within the school community to be conduct disordered, he or she is then thought to be beyond the reach of mental health treatment and responsive only to intense behavior management, a function which many EBD programs consider to be beyond their capabilities.

The link between the conduct disorder label and exclusion often is very direct. A school might say: this child is conduct disordered, therefore, we can't help him. Thus he may be suspended or expelled. Not infrequently, such children have already had contact with law enforcement or the corrections system which, once the child is out of school, must take total responsibility.

Debate among educators and mental health professionals on their roles in behavior management is ongoing despite its formal resolution at the national level several years ago. The issue is whether behavior management is a function of mental health treatment, perceived by some as limited to

internal processes. Formally, behavior management is considered to be part of treatment, but many in the field dispute this conclusion.

Local Actions, Not State Mandates, Determine How the System Works

State mandates have surprisingly little control over how the children's mental health system actually functions. Despite existing laws, local practice and even personal preference dominate service delivery.

Service "varies so greatly depending on the county," said a Northeast Minnesota special education director. "You may have a county that is strong on using the in-home model which may attempt to deal with (problems) early on. In another county, the decision may be that this child should go the route of corrections. In other county or another system, you may end up having the child referred directly to a residential program or more intensive therapy."

"It also depends on the philosophy of the person who is making the first intervention."

Corrections Cannot Serve Juveniles Who Aren't Found Guilty

Juveniles enter the corrections system only after they have been accused of breaking a law. Their behavior is sometimes the result of an emotional disturbance. Many times, delinquent behavior is an indication that these children have slipped through the cracks of other systems that were supposed to have found and treated their disturbances.

Corrections has limited resources with which to address emotional disturbances, relying in most instances on social services for programs and funding. If a juvenile is not found delinquent, the system loses its jurisdiction entirely.

Services Are Not Accessible

Even where services exist in a community, clients without transportation find it difficult or impossible to get to the setting. Rural residents who lack transportation are particularly isolated from services. In metropolitan communities, people who lack money for a personal automobile often find that public transportation does not go where they need to go when they need to get there.

Some Clients Cannot Afford Some Services

The cost of services to clients plays a major role in how the system works. Low income people who qualify for public assistance have a greater access to more services than moderate income people whose resources are insufficient for extraordinary needs. But even medical assistance is no panacea because it is estimated that only one-third of children with an emotional disturbance who need publicly-funded services qualify for MA. In addition, MA cannot be used to pay for some services.

Insurance also fails to provide a safety net for many families. The widespread existence of families without health coverage is well known. But even families with health coverage through a private insurer or a health maintenance organization find limits on the amount of service they can receive, restrictions on the type of service, or insurer refusal to accept mental health treatment as a medical expense. Research suggests state and federal laws contribute to these inequities.

Inaccurate Assessments Result In Inappropriate Service Provision

The assessment tools available to county intake personnel and others who must make service decisions are not always sophisticated enough to pinpoint a child's problem. The difficulty has both cost and treatment implications. To err toward too little treatment hurts the child. To err toward too much treatment costs more than necessary.

Mental health and medical professionals face the same difficulty: any two professionals looking at the same child frequently conclude with different diagnoses. A county intake worker told this story:

"A parent I knew felt her child was different. She went to a psychologist. The psychologist found out that the father had slapped the child once and so that's why the child was having this problem. Then, the first grade teacher recommended a neurologist and the child was diagnosed with Tourett's Syndrome. Also, ADHD (Attention Deficit Hyperactive Disorder) is similar to the post trauma syndrome and is similar to a child who has been abused, which is similar to an alcoholic family. The psychiatrist and psychologist have a difficult time because the behavior is parallel."

The current emphasis on including whole families in the treatment strategy adds to assessment difficulties because of the additional people who must be assessed. Fa.nily assessment is further complicated by the short amount of time which workers spend with the family prior to treatment planning.

Assessment inconsistencies will be the likely result when counties become responsible for screening children prior to Rule 5 facility placements, as required in the draft revision of Rule 5.

Hospital Discharge Plans Don't Tie Clients To Community Services

Current hospital practice often forces a client's discharge too early and many hospitals do not adequately connect the client to community aftercare services. Therapy may be delayed or terminated.

The typical stay of less than three weeks in a psychiatric hospital frequently is too short to stabilize a patient, local workers say. Concerned about the liability of releasing an unstable patient, the hospital refers the patient to residential treatment, according to a county social services supervisor. "The hospital would recommend residential treatment because they want to cover their butts," he said. "All that discharge planning is just going through a paper process."

The director of a central Minnesota residential facility agreed: "About 60 percent of our referrals come from in-patient hospitals and rarely is there a good discharge plan. The plan is to move to the next level of service where someone else will take the child and that's about it. They'll call us the day before and say, 'They have to be out by tomorrow afternoon.'"

A residential treatment facility, with a waiting list of several weeks, will be asked to provide an opening immediately.

"All of a sudden you have a kid who doesn't have a place to be," the social services supervisor said. "He can't be home because he's a kid who beats up his mother. He's very hostile and volatile. He's not going to be welcome at the shelter; they're saying he's a real dangerous type of kid. They're going to discharge him tomorrow so maybe you get somebody to take him to the juvenile center or something. You're supposed to come up with all these wonderful plans and get everything in order, referred to residential treatment all in 12 hours."

Other Barriers

A 1989 survey of county social service directors identified several other barriers to an effective mental health system for children. Eligibility and admissions problems were prevalent for in-patient hospitalization, residential treatment, and assessment and out-patient services. Cultural and linguistic barriers exist to many services; prevention, day treatment, assessment, and early intervention services were particularly impacted.

Among the most serious barriers identified by county directors was the refusal of the child or the child's family to accept the service proposed by the mental health professional.

V.

RATIONALE
FOR SYSTEM INTEGRATION

The system that serves emotionally disturbed children crosses institutional lines and service models. The system's shortcomings also cross those lines. Resolving the barriers which bog the system down in inefficiency and ineffectiveness will require cross-agency solutions.

The divisions in the system are artificial because they are designed often to respond to mere consequences or symptoms of underlying problems. Emotional disturbance, educational failure, and delinquency seem to have common roots. The forces in children's lives which cause emotional disturbance in one child may just as easily be manifested in a medical malady, anti-social or violent behavior, abuse, or family trauma in another.

Yet, a "child is viewed differently in the different systems, in the different tracks, be it corrections or social services or education," a residential facility director said. The system organizes its response around various models that call the same problem by different names, depending upon how the problem is exhibited.

A 1991 study by the Minnesota Department of Education, called "A Report on Special Populations", determined several common characteristics among children who had been treated in dissimilar ways by the system. Children who had been placed in residential mental health treatment shared many characteristics with delinquents who had been ordered into correctional detention and also with children who had been placed in alternative school environments.

Such characteristics as environmental stress, family violence, sexual abuse, emotional distress, antisocial behavior, and low self-esteem were not identified as the essential causes of the children's problems, but their common presence among children being treated in different systems suggest that common causes exist for the apparently different symptomology treated by social service agencies, schools, and juvenile courts.

The diverse professionals who participated in our case studies spoke almost as one mind when they described the frequent inability of any single agency to treat all of a child's needs. Just as pervasive was a consciousness that they and their agencies cannot fix the problem.

The most serious impediment to coordinating services for a particular child seems to be the inability of any actor in the

system to take overall responsibility for the child. Our case studies indicate that an agency often will wash its hands of a child if the child's needs are assessed as being outside the of services provided by that agency. A more conscientious professional may attempt to hand off the case to another agency where he/she believes the client could be better served.

Sometimes there is disagreement among agencies over what the child needs and, frequently, those disputes are defined by the perspective of one's professional discipline. Not uncommonly, no agency in the community provides the service needed, so the child is left in limbo.

Ultimately, the child may fall to an agency's hands due to court order or parental persistence. But, often, responsible agencies cannot provide what the client needs and staff find themselves administering a case, rather than treating a child.

The following anecdote from a metro-area probation officer illustrates a worker's frustration at being in the wrong place to help when no one else is willing to take overall responsibility:

"Somebody was saying the child would be assigned a mental health case manager. Oh, really? How do I get a hold of them? I've got a child who's not delinquent. We got him on a misdemeanor assault; he threatened to hit someone. We have him on that and a "mooning" charge. He's real disturbed. His psychiatric reports all come back saying, 'Unless this child is locked up for at least a year'...not residential, they want him secure...'he will develop a significant personality disorder.' We're recommending a group home but the court hasn't ruled to take that risk because the psychiatrist was so adamant that this kid must be locked up. It puts us in a terrible bind because the only thing we have for the kid are correctional kinds of programs. Bar None says he doesn't qualify because he's not assaultive. I have access to in-home services because we have a contract. But this mother refuses to have her kid at home. We've attempted foster care but he absented from there. I hate to tell you, but social services had a file open. As soon as he got charged criminally for the assault, they closed the file. So there's nothing I can do except place the child. I know the that course we're on, you know, giving him the identity of a delinquent for threatening to hit somebody and not even accomplishing it, is not the way to go."

In many communities, workers in various agencies routinely consult on a particular child. When this does not happen, it is because workers have failed to establish effective relationships, not because they fail to recognize the need to talk. When they do consult, mental health is not the mutual focus. That is, they do not have the sense that they are all there to help the mental health workers to solve mental illness. Instead, the perception of workers is that all aspects of care represented by each of the collaborating agencies are part of the ultimate solution to the child's overall problems.

The question which faces the Task Force is how to restructure children's mental health funding to support an integrated service delivery system.

Thus, the Task Force must define its concept of an integrated fund, since several interpretations exist. The Legislature provided no definition but simply orders the task force to "examine all possible county, state, and federal sources of funds for children's mental health." Specific sources the task force must consider include:

- Medical Assistance;
- Title IV-E of the Social Security Act
- Title XX Social Services funds
- chemical dependency funds;
- education and special education funds;
- funds for developmentally disabled (for dual diagnoses)

Other sources which the Statewide Task Force should consider are:

- Family Community Support Services grant funds
- Community Social Services block grant funds
- Family Preservation Act funds
- Federal Mental Health Block Grant funds
- Community Corrections Act funds
- Sex offender treatment funds
- Title II-B of the Job Training Partnership Act
- Minnesota Youth Program funds
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds
- Office of Juvenile Justice and Delinquency Prevention funds (U.S. Department of Justice)
- Federal Office of Drug Policy funds

Discussions with professionals working in the system suggest several definitions for an integrated fund.

The most far-reaching concept suggests that mental health for children is far bigger than the therapies and services designed to treat emotional disturbance or mental illness. Emotional disturbance, chemical dependency, delinquency, and educational failure, say proponents of this view, are all results of the same social and personal problems. Poverty, family stress, and social and moral turmoil exacerbate each of these conditions. Therefore, funds and services designed to treat any of these conditions have an impact on all of the conditions. The most flexible and most useful fund, they say, would be a "children's fund" which would serve all needs of children.

Another concept would combine into a common pot multi-agency funds targeted to emotionally disturbed children. It would include funds from the departments of Human Services, Education, Health, Corrections, and Jobs and Training with federal mental health grants, federal social service block grants, and local dollars. It may include some portion of non-mental health dollars which serve emotionally disturbed children.

A reduced version of the same concept would combine just Department of Human Services-administered dollars for emotionally disturbed children into a common pot.

An altogether different notion defines an integrated fund not as a combination of dollars but as a series of agreements among agencies which would determine who provides a given service and who pays for it.

Many states are experimenting with a variety of funding strategies for children's mental health service. Their goals are amazingly similar and fall into line precisely with some of the primary policy goals expressed by the Minnesota Legislature and county professionals: (1) to promote coordination of services across agency lines; (2) to provide funding that is flexible enough to respond to individual client needs; (3) and to liberate dollars for the expansion of community-based treatment.

Ultimately, front line children's professionals say the needs of Minnesota's children cannot be met without greater commitment of dollars. But the state must add new money only in ways that enhance its programmatic and policy directions. The current non-system of children's mental health is inconsistent with policy goals expressed in the Comprehensive Children's Mental Health Act since it funnels the majority of dollars into residential services which help a minority of children.

The current state revenue crisis renders the infusion of new dollars improbable in the short term. But, by using the next couple of years to create a children's mental health system that is effective and efficient, children's professionals can alleviate one fear that frequently makes a lawmaker reluctant to vote for new resources: that is the fear that the state may be pouring new money into a system that wastes existing resources and, yet, does not work.

VI.

INNOVATIVE FUNDING STRATEGIES

Many states have restructured funding to improve their children's mental health systems. Their objectives have included increasing their resources, cutting costs, and improving services. Research has identified more than a dozen strategies being tried throughout the U.S. Following the summaries of those concepts, several state's experiences are highlighted to demonstrate how they have used strategies to meet various goals and address political issues.

The strategies are summarized below:

1. Pool Multi-Agency Funds

A pool of multi-agency, categorical funds -- such as child social services, mental health, education, juvenile justice, and public health -- into a single, flexible pot of money is being tried in several states to expand the array of services available. California and Oregon are using this approach in attempts to increase the pool eligible for federal match dollars. Pennsylvania is exploring a "single stream" system through diversion of state hospital monies, a form of pooling. [Used in California; Iowa, Nebraska, Ohio, Oregon; Tennessee, Vermont; Virginia, Pennsylvania.]

2. Restructure Private Insurance

Private insurers, HMOs, and employers' self-insurance groups are under pressure in several states to expand third-party payments for mental health services.

Those states want to amend insurance laws to expand services or bring private insurance coverage up to the level received by public Medicaid recipients. Minnesota laws regulating private insurers and health maintenance organizations already mandate some minimum standards for children's mental health coverage, but allow service caps and prior authorization from the insurer for services to be granted. In addition, capitation-type arrangements have been made between providers and insurers to allow payments for more services in anticipation that use of in-patient services would decrease. [Used in Kentucky, Pennsylvania, and Wisconsin.]

3. Shifting Funds From Institutions

Re-allocation of funds from one component of the mental health system to children's mental health is underway in some states. Pennsylvania is exploring a diversion of

funds from state mental hospitals and the shifting of funds from adult to children's services. Vermont hopes to re-allocate funds from out-of-state and out-of-county placements. Wisconsin will allocate a base amount to counties for placement and any money the county diverts may be used for community-based services. [Used in Florida, New Jersey, Ohio, Pennsylvania; Vermont; and Wisconsin.]

4. Establish Trust Funds

The so-called "self-sufficiency trust " (SST) provides a mechanism for families of handicapped children to contribute money to their children without jeopardizing the recipient's eligibility for public services. Income from the trust can be used to expand services. [Used in Illinois; Maine; Montana; and Oregon.]

5. Earmark Revenues

Earmarking particular taxes or fees for children's programs can ensure a minimum level of funding, help stabilize a state financial system and, proponents say, increase state revenues. Opponents warn that support for contributions to children's programs from the general fund could diminish, leaving programs with less money in the end. [Used in half of U.S. states.]

6. Create A Family Support Program

A family support program could provide cash assistance to families who want to keep their emotionally disturbed children at home but face unmanageable extra expenses as a result. A Family Support Program exists in Minnesota for the families of developmentally disabled children. [Used in Minnesota.]

7. Establish a Local Children's Authority

Creation of a local mental health authority is, in essence, an attempt to overcome the turf battles which naturally occur when agencies attempt to consolidate funding streams. Since agencies resist giving up control of their dollars, their clients, and their missions, the local mental health authority is a neutral entity which can receive donations of dollars and authority from existing state and local agencies in order to gather those resources around the needs of particular clients. Few mental health agencies, on their own, have been able to consolidate medical, educational, social services, and correctional funding streams, according to Dr. David Mechanic, Rutgers University.

The function of central authorities is to consolidate administrative, fiscal, and clinical responsibility for care. While the effectiveness of this approach is unproven, "it seems reasonable to expect that if administrative entities have greater capability to manage care within a consolidated budget, services will improve," according to Mechanic.

Kansas' Local Children's Authority is not a direct service agency but expends funds through purchase of service agreements with local agencies. This arrangement, according to Professor John Poertner of the University of Kansas, allows quick creation,

modification, or discontinuation of servi as the community's needs change or are reassessed.

The local authority includes information requirements in its structure, providing necessary data to the legislature. It also evaluates service outcomes and assures coordination of individual service planning and provision.

An extensive evaluation of an eight-city demonstration of the local authority concept is underway and should be available during 1992. The demonstration is funded by the Robert Wood Johnson Foundation.

Central mental health authorities have not evolved as quickly or operated as comprehensively as expected. "Local participants underestimated the organizational and political barriers to centralizing control," Dr. Mechanic said, "particularly the difficulty of gaining increased control over state hospital funding."

For any state considering a local children's authority structure, Prof. Poertner recommends two things: First, establish the local authority with boundaries that coincide with juvenile court districts. This unites the two bodies with the greatest impact on vulnerable children's lives. Second, test the concept in one or two communities before establishing it statewide.

8. Restructure And Expand Reimbursement

Reimbursement drives services. Often, the factor which determines whether a client will receive a service is whether an agency can pay for it. Further, services which require use of someone else's dollars tend to be favored. Two approaches to restructuring reimbursement are described below:

Restructuring Reimbursement To Focus Resources. Efforts to restructure reimbursement serve two purpose. The most obvious, of course, is to augment dollars, especially federal Medicaid and Title IV-E funds. But reimbursement structure also can be used to focus resources on neglected populations or change patterns of service.

Medicaid is used increasingly (in one-quarter of cases nationally) to pay for acute inpatient care since such care has shifted from mental institutions to the psychiatric units of local general medical hospitals. Medicaid is appealing to those at the local level where care decisions are made because nearly half the money spent by these decisions is federal.

The problem with Medicaid is that is does not pay for all mental health or related services and it does not pay for all clients. The trick is to restructure Medicaid reimbursements to be consistent with state or local mental health policy; i.e. policy which outlines how clients should be treated.

An additional problem arises merely in the reliance on general hospitals for acute care. These hospitals are independent organizations with widely varying practices on linking clients to outpatient care after discharge. Some hospitals have effective aftercare strategies and eagerly contact schools, mental health agencies, and others who may be in position to assist a newly

discharged client. Others hospitals -- due to tight client confidentiality policies or neglect -- do nothing and contact no one.

"Typically, when I receive a referral like this," a Minnesota residential facility administrator said, "it's a short notice referral that says this kid needs longer term care than we can provide because the money's running out. Please take them tomorrow."

New York designed a system of fiscal incentives for general hospitals to encourage them to treat more clients with severe disturbances and to link them with outpatient programs after discharge. That experience may be instructive:

Hospitals receive a $65 "bridging fee" for successfully linking Medicaid patients with outpatient services within 10 days of discharge. In addition, providers receive a 40 percent premium above base Medicaid fees for providing designated services to Medicaid clients within 30 days of discharge from an acute care hospital.

To encourage optimal lengths of stay, the New York system uses a three-tier payment rate. To encourage stays long enough to stabilize seriously ill people, the system pays a premium above the standard rate for the first 14 days of care. To discourage excessive stays, the system pays a cut rate after a month.

Restructuring Reimbursement To Enhance Revenues. Revenue enhancement is understood to indicate ways to manipulate service definitions and eligibility requirement in order to augment federal dollars flowing into state and locally-administered programs. It serves two purposes: first it increases the total dollars available for services in Minnesota; second, for dollar-strapped state and local governments, it is a way to pass off the costs of program growth to the federal government.

From the standpoint of the average taxpayer, revenue enhancement is irrelevant at best and deceptive at worst because it all comes out of his pocket. Nevertheless, states make the argument that federal pockets are deeper. In Minnesota, the argument goes a step further and claims that the state does not receive its fair share of human service dollars due to federal allocation formulas. Revenue enhance strategies are described below.

a) **Capitation** is permissible under the Medicaid 1915(a) option.
A pre-paid, capitated funding approach means that a provider receives prepayment for a defined package of services for a particular client. The provider agrees to the risk of costs exceeding the capitated amount and, thus, has incentive to manage carefully and, particularly, to prevent unnecessary in-patient care. Such incentives, of course, involve some risk to the client who may be denied necessary care.

However, results in communities where capitated systems are operating suggest that "outcomes comparable to those from conventional care can be achieved at much lower cost," according to Dr. David Mechanic of Rutgers University.

Proponents say capitation, by tying dollars

to a particular client, can direct care to difficult or unattractive clients who are prone to rejection by providers.

In addition, capitation is viewed as a way to bring fragmented funding streams together as some level before dollars reach the client. Thus, treatment is not selected based upon the eligibility of the client for particular funding sources. The purpose is to enhance flexibility of service delivery.

The danger of capitation, according to Mechanic, is that it is complicated and "few administrators of mental health systems have the technical expertise or the professional self-confidence to negotiate the necessary agreements, calculate the appropriate capitation allowances, or work out complicated arrangements for sharing risk...These factors explain the gap between interest in capitation and implementation of a capitation system."
[Used in California; Ohio; Oregon.]

b) **Early and Periodic Screening, Diagnosis, and Treatment** (EPSDT) may be expanded to increase Medicaid reimbursable services to children without having to offer them to adults. It would allow emotionally disturbed children to receive mental health services, including in-home therapy, across multi-service systems. Congress strengthened this provision in 1989 clarifying that screening should be periodic until the child is 21 years of age and by requiring states to provide coverage to problems identified in the screening even if the follow-up services are not covered in the state's Medicaid plan. Minnesota used the EPSDT "children's only" limitation to begin home-based mental health services in January, 1991. [Used in California; Minnesota; Pennsylvania; Wisconsin.]

c) **Use Special Education To Bill For Health-Related Services.** In 1988, special education programs were given authority to have Medicaid reimburse psychological and related services provided to emotionally disturbed children. No states have yet implemented it.

d) **Develop a third-party billing plan.** Medicaid can fund related services under a child's Individualized Education Program. Several states have developed a third party billing plan to ensure that the education department recovers some of the cost of providing "related services" to children who are insured or Medicaid eligible. States have fared well by the program, but it is complex and carries a significant concern: if the insured party is denied coverage or rates are increased because of third-party billing, the education department could be held liable. [Used in Connecticut.]

e) **Expand non-waivered Medicaid services**, such as the rehabilitative services option, which would allow reimbursement for a wide range of non-clinic-based services. It is the only category that can be used to cover home and community-based services provided by unlicensed mental health practitioners. Rehabilitative services are defined as any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability. Minnesota has used the rehab option for many years for day treatment and recently expanded its use to pay for home-based mental health services.

[Used in California; Kentucky; Maine; Minnesota; North Carolina; Ohio; Washington.]

f) A **Medicaid Waiver** could reimburse a range of home and community based services to children who would otherwise require institutional care to receive public dollars. A major Medical Assistance expenditure for institutions would first be needed for this to work. [Used in Vermont.]

g) **Use Mental Health Authority Resources As Matching Funds.** Although the dollars used to expand Medicaid coverage historically have come from the Medicaid agency's budget, the Mental Health Division's budget may be used as a matching fund to expand Medicaid use.

h) **Strategies to Enhance Case Management.** Case coordination activities and multi-agency case management involving authorization of services can be Medicaid reimbursed under fee-for-service and prepaid capitated arrangements.

According to 1991 survey of all 50 states by Fox Health Policy Consultants, Washington D.C., states are claiming medicaid reimbursement for care coordination services using six basic approaches:

1) State administrative expense
2) Targeted Case Management
3) Direct billing code for collateral contacts with parents, teacher, providers in already-covered treatment
4) Indirect reimbursement via folding coordination into treatment
5) 1915(b) Freedom-of-Choice Waiver to manage specialty physician costs
6) 1915(a) pre-paid capitated contract without a waiver

Of the six, Minnesota uses the Targeted Case Management and Administrative Expense approaches.

Case management is an integral part of coordinating a client's care among the various providers and agencies involved. How it is funded becomes an important link between issues of funding strategy and coordination of services.

Minnesota reimburses costs related to the "proper and efficient" administration of the state medicaid plan; it does not use it for federally allowable EPSDT administrative case management. Minnesota applies the method to all MA enrollees, though federal rules allow coordination activities to be targeted to specified groups. Reimbursable activities include assisting with intake procedures, assembling an assessment team, scheduling appointments and following up. Activities cannot include therapeutic activities or coordinating non-medicaid services.

Minnesota forfeits the enhanced rate of 75 percent of staff time because the state has not forced counties to use medical professionals to provide these case management activities. Since many counties use social service staff to coordinate services for SED children, the entire state receives only the standard 50 percent reimbursement.

The advantages of this approach are that it does not require a state plan amendment and there is no need for providers to submit claims for direct services in order to secure reimbursement.

Disadvantages are that the care coordinator has no authority to control client's use of mental health services and that SED case management cannot be contracted to a private provider since this approach reimburses only case managers who are public agency staff.

Aside from Minnesota, only Oregon and Pennsylvania use this method of reimbursement for service coordination. Oregon uses medical professionals and receives the enhanced 75 percent rate.

Since not all types of care coordination services needed by children can be reimbursed as a state administrative expense, Minnesota uses this approach in conjunction with "targeted case management" in order to pay for the multi-agency coordination that SED children require. Careful delineation is required as to which activities are reimbursed under each method.

Targeted Case Management is defined expansively under federal medicaid law to include activities that help clients gain access to medical, social, and educational services. Thus coordination activities can be reimbursed for any service needed by a MA-enrolled SED child or his family; it is not limited to only MA services. States may target services to any high-risk population, since this category is exempt from normal medicaid comparability and statewideness requirements. Rules also allow exemption from the freedom-of-choice requirement to the extent that states may specify providers; Minnesota has designated counties as the qualified case management agency, but counties may designate community mental health centers, schools, or other agencies as MA case management vendors.

Targeted Case Management is used in Minnesota only for severely emotionally disturbed children; those at risk or manifesting milder emotional disturbances are not covered. Reimbursement is limited to six hours of service per month; 21 other states do not limit billings.

A medicaid plan amendment is required for this category of reimbursement and providers must track services to specific clients. Another disadvantage of this approach is that a case manager has no authority to restrict inappropriate use of MA.

9. Empower Parents

The popular notion of "empowering" parents should be considered from an economic point of view as a means to increase the system's efficiency and effectiveness.

The notion means, simply, to use the system's resources to help parents help their own families. Although the empowerment of parents has become something of a cliche, the idea has objective merit.

Families bear the first level of social and financial responsibility for children in this society and family ties are seldom severed completely even in poor or dysfunctional

families. The argument holds that, by providing a few resources to a family, the system can bring that family's resources up to the threshold at which the family can support its own child. Public resources are, thus, leveraging family resources.

Such an approach benefits both the system and the family. The system obviously benefits by transferring the burden of caring for some children back to the family and freeing case management for families which cannot be salvaged. The family benefits by gaining what it needs to remain intact and functional.

Local workers say that families of emotionally disturbed children live under intense stress. Much of the stress, naturally, results from the disturbance itself. But the demands of obtaining help from the system are a major source of family pressure. Time must be taken from work; long distances must be traveled; costs must be paid; conferences must be attended. But, first, services must be found and demanded. If the family is headed by a single parent, the pressures are compounded.

One mother of an emotionally disturbed child told of her good fortune in finding a therapist who was cognizant of the stress she faced. The therapist was able to provide enough emotional support to allow her to continue being an effective parent.

"I'm promoting that as a possible solution to not having enough staff to deal with these kids," the mother said. "Every kid has a parent. Maybe this parent is just worn out, just can't do it by herself anymore. If we can find ways to give parents support to keep it going, maybe we don't need as many professional people working with these kids."

George Tetrault, Director of the Minnesota Learning Center in Brainerd, further refines parental empowerment with his concept of "inter-generational interventions":

"We're constantly looking for more cost-effective models. I think we have to look at assessment packages that look at inter-generational change in terms of parenting and in terms of functioning as a family. Those are the kind of interventions that we need to look at. They should be low intensity, but they should be pervasive and they should last over a long period of time and be delivered in the community. The whole focus right now is to get in and get out as fast as you can and not be intrusive."

The concept of supporting parents is formally recognized and nationally promoted by inclusion in P.L. 99-457, the Education of the Handicapped Act Amendments of 1986, which outlines federal policy on serving young children with handicaps.

10. Combine Strategies

Dr. Mechanic believes that using any one of these strategies alone makes for a fragile system. In an article in "Hospital and Community Psychiatry, August, 1991, he stated that a coherent, coordinated system of care must be combined with financial incentives and funding structures which support it. "Capitation, by itself," he says, "creates incentives for managed care and resource development. But it does not ensure optimal clinical decision-making and

may, in the absence of clear clinical direction, erect deterrents to needed care. Joining capitation to an assertive care program creates potential for benefiting from the special features of the funding arrangement while maintaining a clear focus on funding priorities."

Highlights Of Other State's Actions

California

California has transfigured the whole of its mental health, health, and social services systems. The changes include funding structures, service delivery, and information reporting.

The impetus was a major, long-term budget crisis which had caused revenues for mental health and other social programs to drop precipitously. The transformation -- what California calls its state/local "realignment" -- resulted in a new model that served to rescue both Sacramento and the counties. The state escaped responsibility for huge social programs that were dragging its budget into the abyss, while the counties achieved a stable, growth-oriented funding source and nearly absolute control of programs.

Mental health programs -- along with health, juvenile justice, and social services -- had suffered from severe statutorily-triggered budget cuts; mental health programs was slashed more than $160 million between 1989 and 1991, or 35 percent in a two year period.

At the same time, clients and local program administrators suffered under what counties called "a byzantine matrix of state laws, mandates, and regulations" which served clients poorly and wasted precious resources on "useless planning and coordinating activities". The state was the frequent target of lawsuits launched by clients and counties.

Responsibility for mental health and other programs was shifted to counties with a corollary increase in local flexibility, discretion, and effectiveness. Numerous mandates were repealed. Counties were required to provide a comprehensive array of mental health services. Plus, they were allowed to develop eligibility criteria which narrowed the child and adult mental health client population to those who are severely mentally ill and those who require one-time acute care, crisis assessment, or involuntary treatment.

In exchange for the added responsibility, a county-accessed trust fund dedicated to mental health, health, juvenile justice, and social services programs receives all the benefits of a one-half cent sales tax and increased vehicle licensing fees. Mental health will receive 52 percent of trust fund dollars. The trust fund is protected from on-going annual budget cuts (4 percent for 1991-92) which still affect other state-funded programs and is expected to grow by 7-to-8 percent a year.

In addition, Realignment transferred state hospital and Institute for Mental Disease dollars to counties. While it required counties to contract back to the state for institutional services in 1991-92, thereafter counties may redirect those dollars to other uses.

Counties will not be required to spend more on programs than specified amounts. However, the trust fund does require a 35 percent local match.

The effect of the trust fund mechanism was the consolidation of all fiscal resources. At counties' behest, the trust fund maintains three distinct accounts to retain separate identities for mental health, health, and social services programs. The trust fund also keeps social program dollars separate from other local funds to protect them from use in other local government functions such as road maintenance and law enforcement.

The Realignment increased state responsibility for programs, such as AFDC, where the state holds all decision-making authority.

Reporting and evaluation have been simplified, standardized, and consolidated drastically. Counties must develop program performance outcome criteria. However, Realignment has halted state-required mental health and social service plans and eliminated cost reports, audits, and budgets for non-medicaid programs. Quality-assurance audits and cost reports for the medicaid programs are required in sufficient detail to meet federal standards.

Realignment legislation established five commissions or task forces to further develop policy for various programs.

Florida

Florida's use of a special taxing district to fund children's services is rare; in common application, a taxing district provides such services as fire protection, flood control, or hospital care.

Authorized by state legislation and local referendum, the children's services councils were established as independent, special districts of two county governments. They can levy a property tax of up to one-half mil.

The councils fund initiatives based on local needs assessments and must plan, coordinate, and evaluate service delivery.

Iowa

In Iowa, two county pilot projects established child welfare fund pools from dollars that would otherwise have been used for foster care, family-centered services, subsidized adoption, day care, local purchased services, juvenile institutional care, state hospital school care, juvenile detention and juvenile justice, and the county's direct protection and foster care services.

The state contributes state agency funds which would have been allocated to the pilot counties in categorical grants to the pool. A pilot county may also elect to transfer funding provided to youth under Medicaid to the pool, including funding for psychiatric hospital services.

The pool has resulted in many new local services, including day treatment, in-home treatment, transportation, respite, after-care, parent assistance, flexible housing, and a family assistance fund.

Kansas

Kansas has integrated funding and service delivery in the broadest possible manner, assisting "at risk" children across the traditional service disciplines, encompassing problems ranging from mental illness to abuse.

Pooling of funds occurs in a two stage process. First, federal and state dollars are pooled by a new single state children's agency, after first maximizing federal fiscal claims. These combined funds are then channeled to the local level and pooled with local tax dollars.

The integration of funds and service delivery is created at the local level by way of what Kansas calls the "Local Children's Authority", which administers all monies spent on troubled children from the community.

Kansas views the Local Children's Authority as a way to increase flexibility and effectiveness of current funds, since the state's fiscal condition offered little hope for the infusion of additional dollars.

All current service providers are eligible to provide services on a contractual basis and the local authority is responsible to ensure that its contracts satisfy existing federal and state mandates relating to children's services.

Maryland

Maryland is diverting state agency appropriations for out-of-home care and out-of-state placements to local entities who will expand community-based services according to an inter-agency plan. Local initiatives for family preservation projects also will benefit.

Local initiatives will share in savings from a planned reduction in out-of-home placements and will have responsibility for interagency planning, implementation, and monitoring of services.

Authority for the diversions comes from the Governor's Subcabinet for Children, Youth, and Families. Funds from four state departments -- health and mental hygiene, human resources, juvenile services, and education -- will be tapped.

North Dakota

North Dakota has authorized local case managers to use the state's so-called "flexible fund accounts" to respond to unique child and family needs. Workers may purchase goods and services that are necessary to stabilize a family during a crisis situation.

Case managers can spend up to $200 per family on their own authority; expenditures up to $1,000 require supervisor approval; and greater amounts must be approved by the local interagency board. Examples would be rent deposits, food, alcoholism treatment, emergency child care, enrichment programs for children.

The state's experience suggests that the quick command of small monies can greatly boost a worker's ability to help a family avert crisis.

Oregon

County case managers in Oregon's pilot county develop a package of services around a specific client; then the county writes up a purchase order to a single provider to pay for the entire package. No billing is required. From the case manager's point of view, the only difficulty with the system is finding a sufficient number of providers who are willing and able to provide a complete array of services.

What makes this enviable ease possible is an interagency pool of state-level dollars which not only eliminates the fragmentation of categorical funds but increases the state match from which to claim "substantially" greater federal medicaid dollars.

The Partners Project is a joint effort of the local school district, child welfare office, and mental health agency which pooled substantial parts of their budgets. The state medicaid agency holds the consolidated fund and administers the federal match process. If a client is medicaid-eligible, the medicaid agency draws down federal dollars; if not, the agency pays for services with state funds. If the client later goes through the Supplemental Security Income (SSI) process, the medicaid has all necessary records of care received.

To the state, the project is revenue neutral. While it costs more federal dollars, federal officials are tolerant because the types of clients being served are those which will eventually cost even greater federal dollars if they are not treated early.

Pennsylvania

Pennsylvania is trying to establish, statewide, one county's practice of billing Title IV-E for the activities of its juvenile probation officers when involved in services designed to prevent out-of-home placement. The practiced already has passed the federal 427 child welfare audit.

In addition, the state is trying to negotiate with HMOs and state employee health insurers to include a package of covered services that is as broad as those provided to Medicaid clients regulations. It is not viewed as a money-saving measure but as an attempt to provide more services over a longer time period.

Virginia

Virginia created a state-level interagency funding pool which is accessible to local agencies on behalf of individual children whose needs cannot be met with current resources or mandates. Local interagency service projects must develop a comprehensive education and treatment plan.

Wisconsin

In Dane County, Wisconsin, the Program for Assertive Community Treatment (PACT) uses a multi-disciplinary, continuous care team that "serves as a fixed point of responsibility" for a group of clients and is concerned with all aspects of their lives. The teams work with clients in their homes and workplaces carrying on treatments of varying intensities and are available

24-hours-per day. They also work with community members and act as "gatekeepers" for inpatient care.

The state gives Wisconsin's counties a global budget that allows them to trade outpatient care for inpatient care.

But, according to Dr. David Mechanic, it is not known which components of the Dane County model contribute most to its success. "It is a complex system of interventions that is unlikely to be adopted in its totality" elsewhere. Nor is it understood why some county systems in Wisconsin continue to operate as hospital-oriented systems or why other states with comparable financing incentives vary so greatly in the kinds of systems that evolve.

VII.

MINNESOTA'S COMMUNITY-BASED SERVICES DEMONSTRATION PROJECT

Minnesota has recently concluded a three-year, eight county children's mental health demonstration project which illustrates the potential benefits of granting increased local flexibility and of cooperative relationships between counties and the Department of Human Services.

An independent evaluation of the project determined two primary reasons for the project's success:

First, the project provided funds with few financial restrictions or conditions, allowing the counties to develop and implement services which met local needs. These were services which have been mandated by the Comprehensive Children's Mental Health Act but which, nevertheless, had not been available in those communities before.

Second, county staff met periodically with the state project supervisor to share information, establish accountability, and provide face-to-face technical support. These relationships fostered creativity by reducing paperwork and local fears related to accountability.

The evaluation indicated that the quality of services provided to clients in the demonstration counties increased as a result of local efforts to coordinate services across agencies.

Productive interagency relationships, however, are fragile. Coordination demands a great deal of trust, especially among agencies that have been historic rivals. The philosophical perspective from which each agency and each professional operates must be recognized.

The various agencies must (1) develop a common language, (2) evaluate a client's readiness for services, (3) establish a system for jointly and separately providing services, (4) cultivate a joint sense of ownership for the child's welfare regardless of point of entry, and (5) allocate resources within the constraints of each agencies limits.

Effective coordination still faces many barriers in the Minnesota environment. Bureaucratic and financial obstacles slowed progress. Project staff said that funds targeted for narrowly defined groups thwarted service coordination. Paperwork was stifling.

In addition, the "outcome-oriented" ideology of the community-based policy is in conflict with process orientation of the existing system.

Coordination of effort demands a great deal of staff time and effort; however, staff view the effort as worthwhile.

The demonstration projects faced barriers at a broader level also. Locals staff's failure to develop common goals, or sufficiently educate members about the goals of the project were limiting factors at some project sites.

Among the feats of the projects were lower costs, more efficient service delivery, greater interagency awareness and professional networking, and reduced tensions among former rivals.

The net result for the community was that fewer needy children slipped through the cracks of the system. Families were able to get through the system faster and new services have kept more children in the community.

Expanded services particularly effective at keeping children in the community were the home-based and school-based therapies.

Flexible allocation of both joint and separate resources allowed counties to implement and operate more expensive programs such as day treatment and summer schools.

The evaluation recommended that the state:

- design additional programs based on those elements that made the demonstration projects successful;
- continue to fund programs which promote coordination of services and delivery systems;
- continue to support and develop home and school-based services;
- develop services which meet the specific needs of families;
- educate personnel across the state to ease the major paradigm shift required to go from a process-oriented to an outcome-oriented system;
- avoid quick fixes until a statewide plan for delivering coordinated services is developed.

Counties view demonstration projects as a positive incentive, according to our case studies. But the incentive has lost some of its appeal as county boards, who misinterpreted the purpose of a demonstration project, have learned that the new money does not continue after conclusion of a demonstration. "Counties have been much more suspicious about those things they take to the board anymore," a social service director said. "The intent of the two-year demonstration thing is to set up expectations that the counties can't back out of. But the county is getting kind of smart to that."

VIII.

CONCLUSIONS
OF RESEARCH AND ANALYSIS

One
Solving the problems of the children's mental health system will require integration of its uncoordinated components. While coordination at the state level would eliminate many barriers to an effective system, integration must take place at the local level.

Minnesota's community-based service delivery system is disjointed and is different in every community. State-mandated procedures for interagency coordination have limited effectiveness. In contrast, locally-initiated informal networks have proven effective at the individual case level in communities where they have been established.

The existence of locally-initiated coordination networks, however, is inconsistent. A mechanism which exempts communities with effective coordination networks from mandates while enforcing mandates on counties which have failed to coordinate services would likely be well-received by counties.

Two
The fragmentation of the existing funding, service delivery, and information systems means that the total resources of the system are never available to any single actor. Thus, no single professional can assume the responsibility to identify a client's overall needs or to design an effective and efficient package of services to meet those needs.

Eligibility criteria applicable to most funding sources contribute to fragmentation by forcing professionals to match a client's needs with funds that are eligible to pay for needed services. Frequently the professional must choose the service which is available, rather than that which is most beneficial.

Three
Residential services will continue to be needed to meet the needs of emotionally disturbed children, but establishment of a full continuum of community-based services is crucial for earlier intervention.

The fiscal efficiency of the children's mental health system is in no way defined by the debate over residential versus community-based treatment. It is much more useful to view conflict within the system as a contention over selecting the stage of a disorder at which to apply the system's resources.

There is insufficient evidence to conclude that a community-based service delivery system would be more cost-effective than residential treatment. In addition, the establishment of a full continuum of community-based services may not immediately reduce the need for residential treatment because there is a backlogged demand resulting from growing and increasingly severe caseloads.

Four

While the Comprehensive Children's Mental Health Act requires counties to establish services for all emotionally disturbed children, responding to the crises presented by the most severely disturbed children overwhelms most resources, leaving little or nothing for early intervention and the less severely disturbed. Large numbers of children do not receive mental health services because the disturbances they exhibit are not severe enough to command a high priority.

Five

The existing funding structure is sufficiently flexible to allow establishment of mandated home-based and community support services. That the dollars are not actually shifted within the system to establish these services is the result of local treatment and funding choices which are responding to continued demand for residential and hospital treatment for crisis cases.

Six

Greater funding levels are needed. Dollars cannot be shifted away from residential services and crisis treatment because abandoning the most severely disturbed children would create adults who are even less healthy, dangerous to society, and more costly in the long run.

Seven

Integration of mental health treatment into schools would provide the greatest access to the greatest number of emotionally disturbed children while, at the same time, distributing responsibility to agencies whose job it is to provide treatment.

Schools are not designed to treat emotional disturbance. Their mandate is only to eliminate the emotional barriers to educational progress. Thus, schools are reluctant to identify treatment needs because, under the current system, they would then be required to pay for treatment.

Integration also would provide better identification and assessment capabilities than currently available in schools, which tend to overlook emotional disorder in favor of disruptive behavioral problems.

Eight

The corrections system is a key actor in the overall system that serves emotionally disturbed children. While its role is not specifically to address mental illness, many children accused of breaking the law are emotionally disturbed. Although much discussion occurs at the local level as to whether a particular child is emotionally disturbed or delinquent, to a significant extent, they are the same children. Maintaining the distinction between

emotional disturbance and delinquency hinders treatment by allowing the system to say, for example, that a specific child is no longer sick; now he's a criminal. It allows one agency or the other to wash its hands of the child and pass the child off to another agency.

Nine

The private health payment system, like public medical assistance, constrains the mental health care available by way of restrictive criteria in the coverage plan. In fact, many families with private insurance have mental health coverage that is inferior to that available to public assistance clients.

Ten

Providing therapeutic or support services to families has the effect of using minimal public resources to leverage private resources. Often, a little support can make the difference between a family that fails and one that succeeds, thereby supporting its own children.

Eleven

The lack of good data contributes to the fragmentation of the funding structure and the service delivery system. When a service need is identified but information about current activity is unavailable, the tendency of interest groups and legislators is to create a new program. This allows them to target dollars. However, along with the new program comes new bureaucracy and less integration.

Twelve

The various state and local interagency councils and committees established to coordinate services have failed to coordinate their own efforts. Duplication exists both in mission and client-specific activity. For a complete analysis, see Appendix B.

Thirteen

The conclusions of this report are compatible with the directions set in the report of the Governor's Action For Children Commission entitled "Kids Can't Wait: Action for Minnesota's Children."

What is good for all children is also good for emotionally disturbed children. While children with emotional disturbances have needs which are specific to their disorders, what they need from government is essentially the same as all children need.

Among the shared conclusions are these:

- Solving the system's problems will require cooperative efforts between state and local governments.
- Intervention should occur at the earliest possible stage of a problem. Prevention is better than crisis management.
- Information should be integrated across agency lines.
- Education, health, and social services should be integrated around the needs of the child.

- The service delivery system should be designed around the imperatives of the local community.

- Funding should be flexible and joint funding should be allowed.

- Efforts of coordinating committees and advisory groups lack coordination.

- The problem cannot be fixed at the state level. The state should allow community efforts to occur. Where they do not occur, the state should assist.

Fourteen

The Task Force should consider whether private health insurance should be included in an integrated fund.

The passage of the 1992 Health Right law creates a new relationship between state government and the private health care industry. The line separating the two will be somewhat less distinct than it has been in the past.

At the outset of the Children's Integrated Fund Initiative, it was assumed that private sector health care would not be part of an children's mental health integrated fund. Now, however, the Task Force should reconsider this assumption.

Does the new public-private health care relationship engendered by Health Right open an opportunity to include private sector resources in a children's integrated fund?

APPENDIX A
SURVEY OF LOCAL COORDINATING COUNCILS

The legislation to study the feasibility of an integrated children's mental health fund requires each local coordinating council (LCC) to establish a task force to develop protocols and procedures to ensure coordinated and cost-effective planning, case management, and delivery of services to children with severe emotional disturbance. The legislation requests LCCs to report recommendations on consolidating or pooling funds to the state task force studying the integrated fund, as well as to report on recommended protocols and procedures to the Commissioner.

In response to this legislative initiative, the Department of Human Services and the State Interagency Coordinating Council developed a survey to collect information regarding local interagency activities and protocols and procedures. The questions for the survey were based on information requested by the legislature. An instrument was needed to measure Local Coordinating Council members general attitudes and perceptions of current activities and the status of their efforts to implement the Act. The LCCs were asked to complete a survey on:

1) barriers to coordinating services;
2) their activities;
3) complications to providing collaborative mental health services to children and their families;
4) local planning priorities;
5) protocols and procedures implemented; and
6) a list of formal interagency agreements.

By using a survey , DHS was able to determine how LCC members feel towards the legislative mandate requiring their existence and their role in implementing community-based services. The survey will help DHS to identify and work towards eliminating the barriers to coordinated and cost-effective planning, case management, and service delivery.

Surveys were mailed to eighty-seven County Social Services Directors to be forwarded to the chairpersons of the LCCs. Local committees were given approximately six weeks to respond. Fifty-nine councils (69% of counties) responded to the survey.

Questions and Responses

1) What barriers to coordinating services on the systems/interagency level have been encountered by your local coordinating committee? Please check all that apply.

Coordination is defined as occurring when two or more groups or agencies take action as a result of the increased communication developed from being part of a network. Agencies may determine that one or the other is better able to perform a certain service and a decision is made to allow that agency to do so. Coordination can include referral between agencies and the joint publishing of resource material (M. Kerns and M. Stanley, Building Community Partnerships Through Community Education).

Most often mentioned barriers to service coordination are shown in Figure 1, Barriers To Coordinating Services.

The items selected most frequently by committees were inadequate funding (59%), lack of representatives with decision making authority (54%), and lack of representation of all agencies (37%).

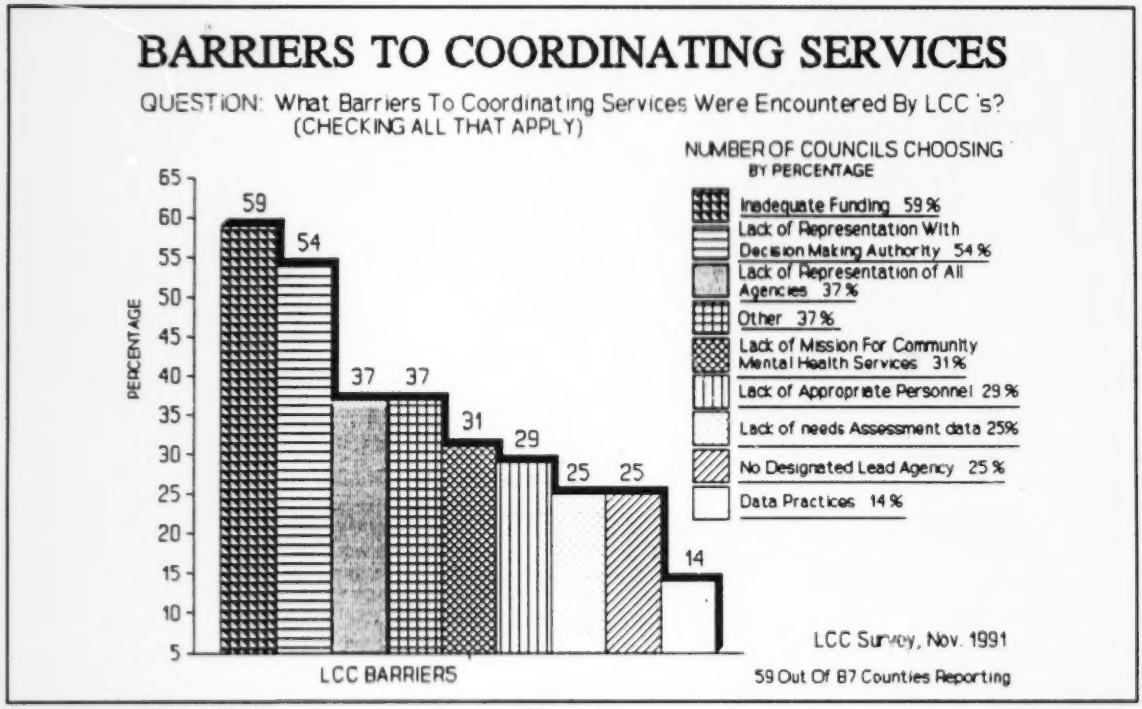


Figure 1

Other items identified by LCCs that create barriers to coordinating services include:

a) geography with the number of school districts and county lines making funding issues confusing;
b) overly broad definition of mentally ill child;
c) overly prescriptive regulations;
d) tremendous amount of time necessary to do the job right;
e) lack of understanding of SED and mandated services;
f) lack of cases;
g) chairperson doesn't set up regular meetings;
h) problem in forming council due to geographic distance, scheduling, and administrative problems;
i) lack of understanding of the role of LCCs;
j) a related concern involves mechanisms or mandates for leveraging dollars from various systems;
k) late start;
l) lack of local resources to meet identified needs;
m) difficult to find consumer representation;
n) various levels of commitment and program development in neighboring counties; lack of "regional" perspective to children's mental health program development;
o) too many interagency meetings with the same people serving on them;
p) lack of coordination of state agencies;
q) lack of understanding of each agency's role and responsibility in providing mental health services; and
r) mental health services have different priorities within each local agency.

2) Which activities of the LCC have been most helpful towards assuring coordinated and cost-effective planning, case management, and delivery of services to children with severe emotional disturbance and their families? Please check all that apply.

LCC activities regarded as most helpful in assuring coordinated and cost-effective services were: (1) learning about the other agencies represented on the council (80%); (2) assessing availability of local children's mental health services (58%); and (3) sharing data among agencies (49%). These figures reflect the activities completed to date, not the overall importance of the activity.

Survey results indicate that these groups are in the earliest stages of developing as effective forces for coordinated action. Before an interagency committee can target local issues and services for improvements, members must come to view themselves as organized partners with a common purpose and mission.
Figure 2, LCC Activities gives a complete listing of activities that have been most helpful to date.

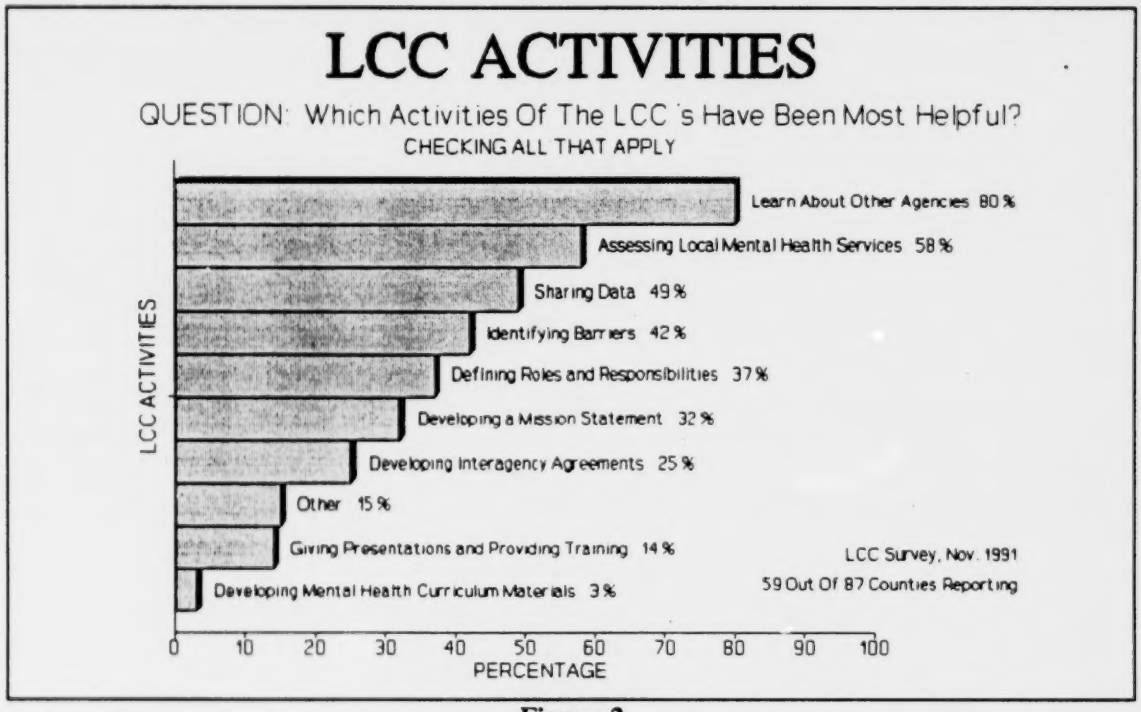

LCC ACTIVITIES
QUESTION: Which Activities Of The LCC 's Have Been Most Helpful?
CHECKING ALL THAT APPLY
LCC ACTIVITIES
Learn About Other Agencies 80 %
Assessing Local Mental Health Services 58 %
Sharing Data 49 %
Identifying Barriers 42 %
Defining Roles and Responsibilities 37 %
Developing a Mission Statement 32 %
Developing Interagency Agreements 25 %
Other 15 %
Giving Presentations and Providing Training 14 %
Developing Mental Health Curriculum Materials 3 %
LCC Survey, Nov. 1991
59 Out Of 87 Counties Reporting
0 10 20 30 40 50 60 70 80 90 100
PERCENTAGE

Figure 2

3) What complications do you face regarding collaboration? Rate the following items according to their anticipated difficulty to coordinate. Check one box for each item.

In collaboration, the autonomy of the agencies is more limited and the common goal becomes as important as the identity of the agency or group. A common mission and organizational structure is formed. Joint powers or interagency agreements are developed and resources pooled. Complete information is shared about the subject of the collaboration. Equal risk is shared by all members of the collaboration. (M. Kerns and M. Stanley, Adapted from Building Community Partnerships Through Community Education)

Collaborative ventures among local agencies requires a considerable amount of time for producing and exchanging information, for planning how fiscal and human resources will be reconfigured, and for evaluating the effectiveness of system changes. Figure 3, "Complications To Collaborations," suggest that: (1) sharing funds (64%); data management (44%); and evaluation (35%) are very difficult areas to coordinate when entering into collaborative agreements for community-based services.

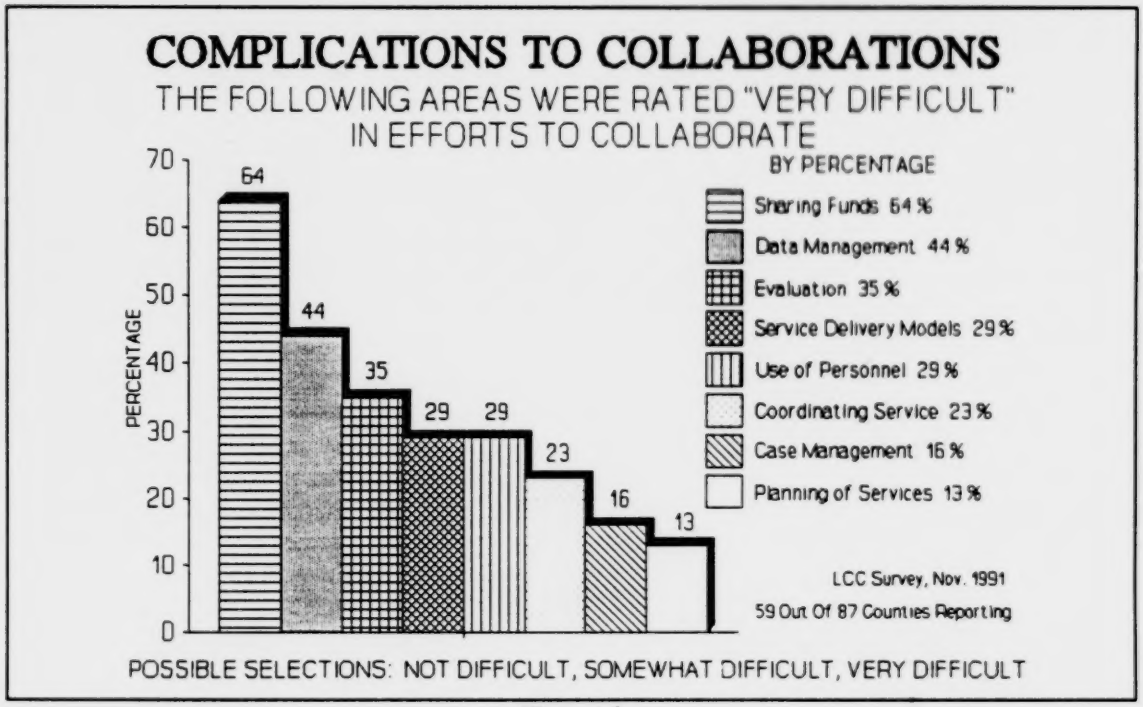


Figure 3

4) Planning priorities: Please rank the top three interagency planning priorities for your committee.

Coordinating services (27%); planning of services (22%); and sharing of funds (17%) were identified as the top interagency planning priorities. See Figure 4, "Interagency Planning Priorities".

While sharing of funds was identified as the number one complication to collaborations committees recognize that, before a group can plan for shared funds, the members must first identify how services will be coordinated and planned for implementation. Ultimately, funding will be addressed; but how and with what fiscal and human resources depends upon the service planning and coordination that occurs up front.

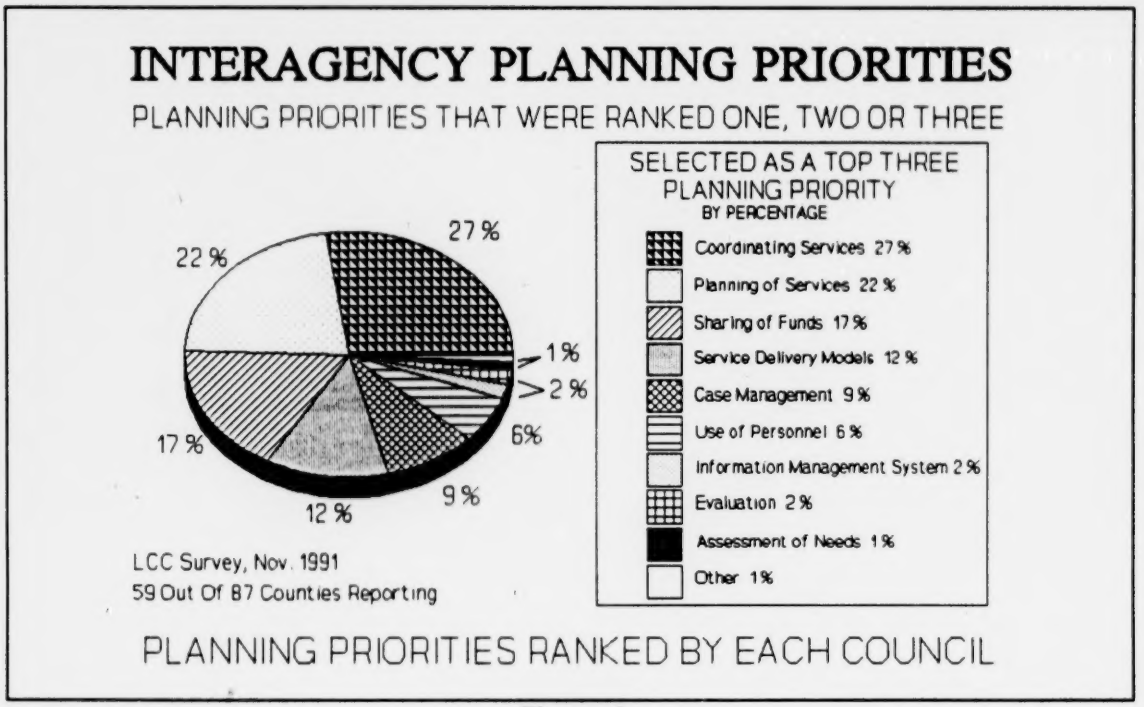


Figure 4

5) Protocols and procedures: Do you have a local task force that has developed protocols and procedures to ensure coordinated and cost-effective planning, case management, and delivery of services to children and youth with severe emotional disturbance?

Eighty-eight percent of the councils responded that they do not have such a task force. The LCC survey results suggest that informal networking and coordination may be happening more frequently because committees are still getting organized and prefer this mode to a formalized organizational structure with by-laws and procedures for committee meetings. As mentioned earlier, 80 percent of LCCs are engaging in activities to learn about each agency represented on the committee and are beginning to assess their local mental health needs.

The mandate for LCCs to establish a task force to develop protocols and procedures was passed in the 1991 legislation as a subdivision to study the feasibility of an integrated children's mental health fund. The request by the legislature may be premature given the initial level of organizational planning occurring at LCC meetings.

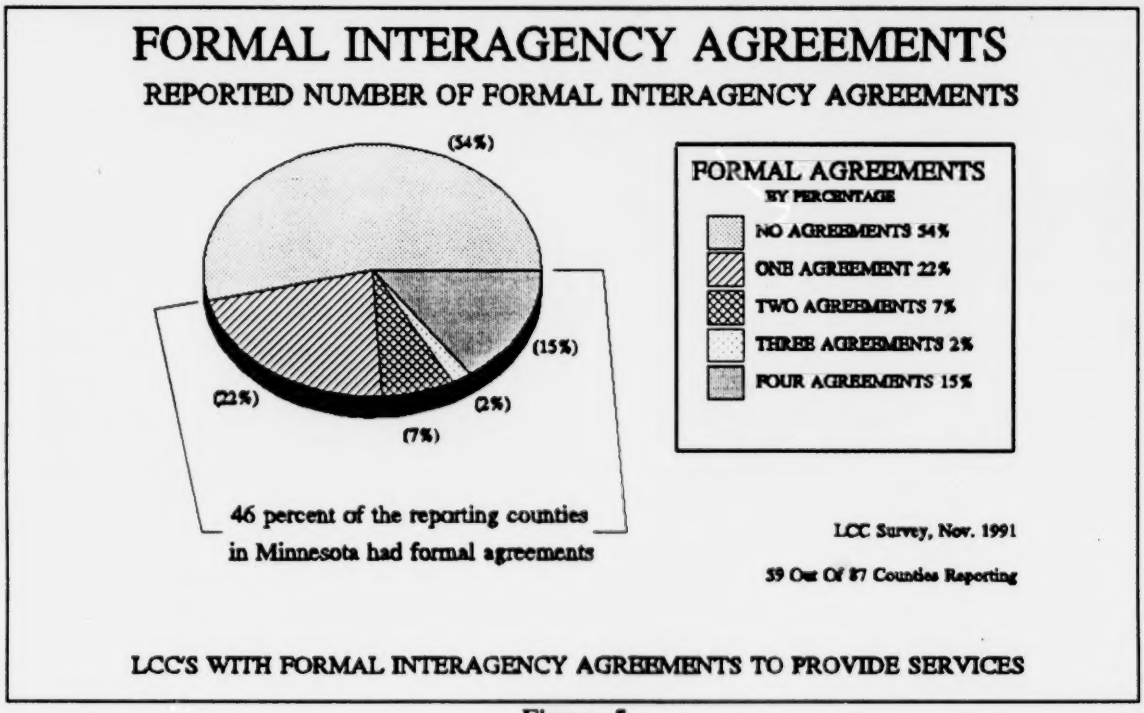


Figure 5

6) Interagency services: Please list your formal, interagency agreements.

One of the duties of the LCC is to develop interagency agreements with local providers, which coordinate service delivery. Forty-six percent of the reporting counties in Minnesota had formal agreements. M.S. 245.4873, subdivision 3 directs counties to create interagency agreements but provides limited funds and limited technical assistance. Figure 5, "Formal Interagency Agreements," shows the number of formal interagency agreements being reported by the counties that responded to the survey.

Survey respondents also identified the services being provided through formal interagency agreements. Day treatment and early intervention and identification were the services most often involved in interagency agreements, Figure 6, "Interagency Services".

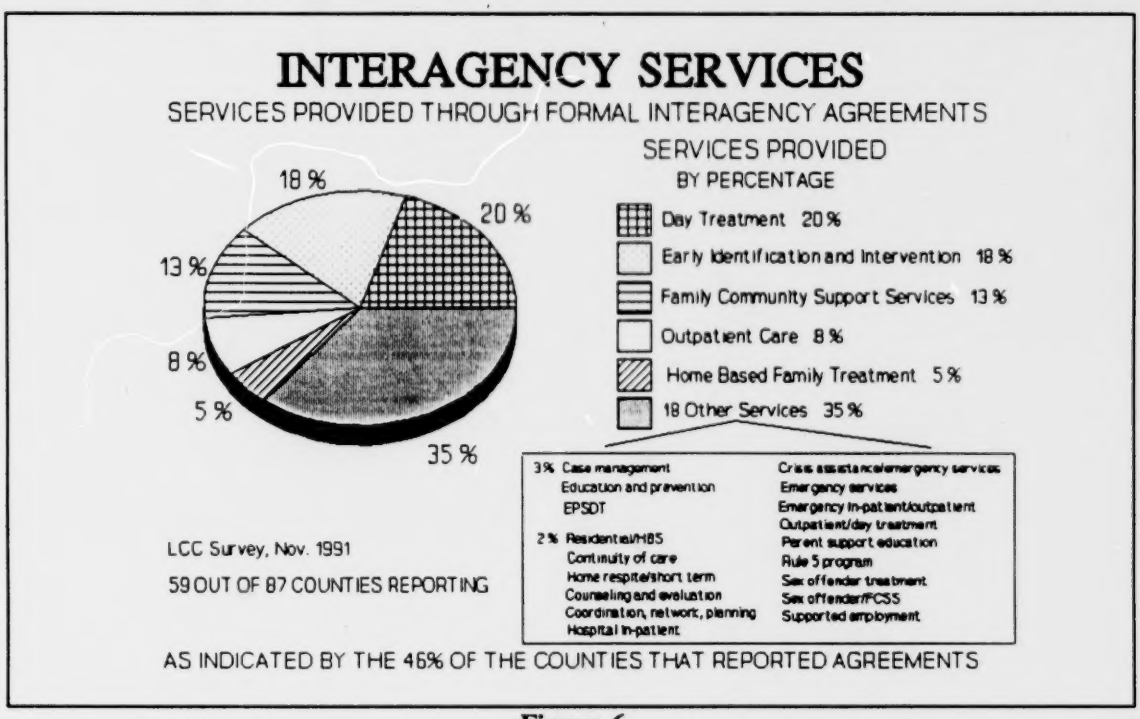


Figure 6

LCC Annual Report

LCCs must submit an annual report to the Commissioner of Human Services that includes a description of the services provided through each of the service systems represented on the council, the various sources of the funding for services with amounts actually expended, a description of the numbers and characteristics of the children and families served during the previous year, and an estimate of unmet needs. Sixty-four out of eighty-seven counties (74%), submitted annual reports to the Commissioner.

Much of the fiscal and descriptive numbers data was accounted for in the county mental health plans submitted by each county. This information has been incorporated throughout this report.

The tools or processes used by counties to identify unmet needs and service priorities are reported below in "Identification Of Unmet Needs".

Early identification and intervention (33%), day treatment (21%), and family and community support services were rated as the top priorities among unmet service needs. See Figure 7, "Priority Of Service Needs".

IDENTIFICATION OF UNMET CHILDREN'S MENTAL HEALTH NEEDS

What tools or processes did the county use to identify the unmet needs and service priorities?

73% local county mental health plans
73% discussion among committee members at meetings
63% actual number children/youth receiving residential care
41% local child count reports
41% state reports/documents
36% actual number of children/youth placed in juvenile corrections programs
34% actual number children/youth receiving out-patient mental health services
31% actual number of children identified by interagency early intervention committees in need of mental health services
25% actual number children/youth involved in day treatment programs
14% survey of parents and children/youth on mental health needs
14% other
9% formal assessment conducted by a consultant or agency on the committee
2% local follow-up study of former consumers

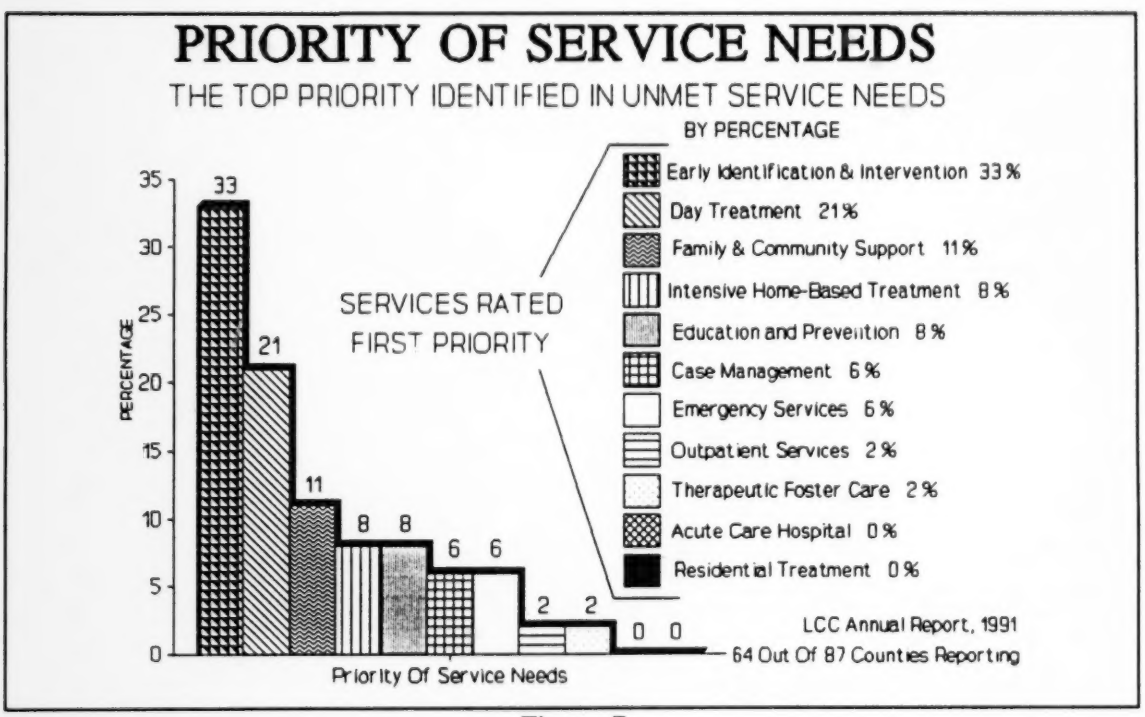


Figure 7

LCCs listed recommendations for improvement of coordination and funding for children's mental health services. A complete list follows:

List your Council's recommendations for improvement of coordination and funding for children's mental health services.

Mission/Vision Recommendations

- Evaluation of strengths and weaknesses/analysis of how things are currently working for children with emotional disabilities and development of an overall visionary plan of how McLeod County would like to serve all children with emotional disabilities. (high priority)
- Increased sensitivity of legislators via on-site visits of services to SED children.
- Create a vision not statutes.

Funding Recommendations

- DHS should mandate services only when providing funds for services.
- Joint participation in grant applications for children's services.
- Technical assistance from a State Department level coordinating council to identify all potential sources of revenue for children's mental health services is needed. Funds from Department of Health, Education, Corrections, Human Services and Vocational Rehabilitation might be used in various ways to provide resources to children and families. Pieces of early identification and intervention, as well as education and prevention services, are provided by many agencies. A more coordinated, long range plan by state departments could help local agencies use available resources more efficiently.
- A straight forward, consistent, and timely message to counties from the Department of Human Services about the availability of a process to obtain additional funds to develop or provide mental health services would be nice. The notification provided in DHS Instructional Bulletin No. 90-53D was not timely. The verbal messages received in some subsequent DHS training sessions were not consistent with this bulletin. The application for the funds and the potential reporting requirements were complicated and costly, especially when compared to the amount of potential funds available to a small county.

- Develop a consolidated children's mental health fund containing adequate money to meet all the needs. Coordination is already adequate in this small county.

- There is a lack of funds and personnel.

- Funding change from so many grants to funding streams that could provide long term support to locally determined needs. (high priority)

- Work towards Medical Assistance eligibility for children separate from their parent's income.

- Funds for co-location of services is most helpful to reach across traditional institutional borders between education, mental health, and social services. County needs staff that are hired with joint funding and joint responsibilities shared among departments of mental health, social services and education.

- An MA/Waiver program similar to the one that exists for MR/RC children.

- The State of Minnesota should fully fund the Children's Mental Health mandate, hopefully with new monies and not at the expense of other social service programs, i.e., adult mental health, DD, child welfare.

- Interagency agreements.

- The primary emphasis of fiscal incentives ought to be upon early intervention and prevention.

- The LCC feels that the Minnesota Department of Human Services ought to negotiate with third party reimbursement agents to deal with the manner in which major activities should be reimbursed.

- Review current funding provided to all agencies who provide services to this target group to determine whether there is a duplication of funding and efficient use of present resources.

- Money allocated directly to LCC for children's services. (including CD, MH, SS, grants, action agencies, and education as is possible and practical)

- CD monies are funding many duplicate programs. Should go through LCC to prevent overlap and promote better use of funds.

- The funding of transportation.

- One stream of funding if possible and where possible.

- Need for funding to pay agencies for lost direct service reimbursement due to collaboration and coordination efforts.

- The Local Coordinating Council has identified several service gaps in the county. A primary barrier in service coordination, particularly in the development of new services for emotionally disturbed children, is the coordination of funding from different agencies. With budget reductions coupled with increased work expectations, counties, school districts, Rule 29 clinics, and other service providers are often reluctant to voluntarily expend dollars, A recommendation noted by the Local Coordinating Council is that at the state level, there needs to be increased cooperation and coordination between the Department of Human Services, the Department of Correction, the Department of Health, and the Department of Education regarding both shared funding of services as well as shared responsibilities in the development and ongoing implementation of services for emotionally disturbed children and their families.

Coordination Recommendations

- Involved agencies should have quarterly meetings of agency representatives that have decision making responsibilities.

- Our council has functioned through our child protection teams. It seems that this is probably not the most effective group to get services developed due to the complicated funding issues that really need to be ironed out by administrators. We are looking at a shift of membership to better accomplish our task.

- Incorporation of the LCC with two already existing interagency committees.

- Development and utilization of community case consultation team for children at risk of developing emotional disturbance.

- Better coordination of diagnosis made by education and mental health to increase delivery of most appropriate and effective services. (high priority)

- Combine the functions of the Local Coordinating Council with the Children's Mental Health Advisory Committee.

- Other agencies required to participate on the LCC do not have the same mandates, therefore it is very difficult to get them actively involved on the LCC.

- Regular individual team meetings by involved caregivers, child and family.
- Participation on the LCC of representatives with decision-making authority.
- We will better be able to comment on coordination after our family community support program is developed.
- As a council, determine/designate folks to be responsible for efforts, i.e., applying for funding through grants. Tap resources of folks within the group.
- A "Statement of Roles and Responsibilities" (which would define which parts of the system would bear the cost) should be developed.
- For those groups not currently included in the LCC, we recommend their inclusion (e.g., insurance providers, HMO's, community organizations, among others). For those groups who have been designated by law as responsible to attend LCC meetings, but who do not attend, we recommend that legislation with appropriate sanctions be designed to mandate their involvement.
- Consider making mandated the responsibilities of the local coordinating councils and part of the duties of the Children's Mental Health Advisory Council.
- Coordinate services and efforts at state level between divisions within Department of Human Services, i.e., children's services, child protection, mental health, etc.
- Clarification and understanding of the council's role in the community.
- Explore ways to coordinate with existing groups, such as the youth network.

Management/Operations Recommendations

- Less paperwork.
- Fewer mandates, greater flexibility, more local control of funding.
- Reduce unnecessary mandates and volumes of documentation which erode actual services to children.
- Allow counties more flexibility in developing services to meet local needs rather than mandating services through state law.

- For each service desired, adequately fund, then identify the operational entity to put service in place.

- Trim back rule setting and minute monitoring so state staff have time for technical assistance and keeping counties abreast of new and other programs in other counties.

Service Delivery Recommendations

- We will continue to collaborate with the local school district to explore the feasibility of day treatment services and to improve early identification and intervention services.

- Earlier involvement with DRS for children having severe emotional disturbances.

- Independent living skills programs for adolescents not limited to those in out-of-home placements.

- More cooperation between high schools and technical college or other vocational programs in providing for needs of older adolescents.

- More flexibility/creativity in providing educational services to children in non-traditional ways; more therapeutic emphasis prior to Level V (day treatment).

- Provide realistic technical assistance for rural counties in regard to implication of a 3-4 hour bus ride for children in a day treatment program.

- Coordinate with schools to identify children with mental health problems.

- We believe that the mandated "Analysis of Strengths and Weaknesses" should drive the assignment of the selection of the agency which provides service. Furthermore, the agency which is thus selected should be the "legal authority", with consequent power to assess cost and make all appropriate decisions. (If the family does not want to become involved in that process, they need not - unless under court order).

Training Recommendations

- Provide coordinated training on a regular basis for LCC usually annually on services, have various agency representatives talk about their programs, eligibility, access, clients served.

- Cross-disciplinary training, with an emphasis upon cultural sensitivity, should be provided for all appropriate staff.

- More education for professionals serving children on emotional disabilities in children.

APPENDIX B

STATE AND LOCAL INTERAGENCY COORDINATING COMMITTEES

Appendix B contains matrixes of these coordinating committees which show each group's mission statement or purpose, responsibilities, committee membership, target population, and statutory references.

The purpose of the matrixes is to offer a framework for thinking about service delivery through interagency initiatives and to stimulate discussion by raising some central questions. It does not provide a comprehensive account of what we know or how we ought to proceed. However, this initial review begs some important questions.

1) Does each committee at the local and state level have distinctly different missions?

2) How are the responsibilities of the local and state level committees the same?

3) Are the same service providers, advocates, and parents required to be members for all of the interagency coordinating committees?

4) Is there duplication in the targeted population to be served? Are several committees dealing with the same children and families?

STATE LEVEL INTERAGENCY COORDINATING COMMITTEES

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
STATE ADVISORY COUNCIL ON MENTAL HEALTH	•Advise the governor, the legislature, and heads of state departments and agencies about policy, programs, and services affecting persons with a mental illness. •Establish and maintain communications with County Boards of Commissioners through County Mental Health Advisory Councils. •Serve as an advocate for persons with serious and persistent mental illnesses, seriously emotionally disturbed children and adolescents, elderly individuals, and other individuals with mental illnesses or emotional problems. •monitor, review, and evaluate the allocation and adequacy of mental health services within the state.	1) Advise the governor, the legislature, and heads of state departments and agencies about policy, programs, and services affecting people with mental illness. 2) Advise the commissioner of human services on all phases of the development of mental health aspects of the biennial budget. 3) Advise the governor and the legislature about the development of innovative mechanisms for providing and financing services to people with mental illness. 4) Encourage state departments and other agencies to conduct needed research in the field of mental health. 5) Review recommendations of the subcommittee on children's mental health. 6) Educate the public about mental illness and the needs and potential of people with mental illness. 7) Review and comment on all grants dealing with mental health and on the development and implementation of state and local mental health plans. 8) Coordinate the work of local children's and adult mental health advisory councils and committees.	The council must have 30 members appointed by the governor in accordance with federal requirements. The council must be composed of: 1) the assistant commissioner of mental health for the department of human services; 2) a representative of DHS responsible for the medical assistance program; 3) one member of each of the four core mental health professional disciplines (psychiatry, psychology, social work, nursing); 4) on representative from each of the following advocacy groups: Mental Health Association of Minnesota, Minnesota Alliance for the Mentally Ill, and Minnesota Mental Health Law Project; 5) providers of mental health services; 6) consumers of mental health services; 7) family members of persons with mental illnesses; 8) legislators; 9) social service agency directors; 10) county commissioners; 11) other members reflecting a broad range of community interests, as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.	People with mental illness	M.S. 245.697

141

142

STATE LEVEL INTERAGENCY COORDINATING COMMITTEES (CON'T)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
THE SUB-COMMITTEE ON CHILDREN'S MENTAL HEALTH	Create and ensure a unified, accountable, and comprehensive children's mental health service system.	The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health.	Members of the subcommittee must include: 1) the commissioners or designees of the commissioners of the departments of human services, health, education, state planning, finance, and corrections; 2) the commissioner of commerce or a designee who is knowledgeable about medical insurance issues; 3) at least one advocate for children with emotional disturbances; 4) at least one service provider to preadolescent children; 5) at least one service provider to adolescents; 6) at least one hospital-based provider; 7) parents of children who have emotional disturbances; 8) a present of former consumer of adolescent mental health services; 9) educators currently working with emotionally disturbed children; 10) people knowledgeable about the needs of emotionally disturbed children of minority races and cultures; 11) people experienced in working with emotionally disturbed children who have committed status offenses; 12) members of the advisory council; 13) one person from the local corrections department and one representative of the Minnesota district judges association juvenile committee; 14) county commissioners and social services agency representatives.	All children ED and SED	M.S. 245.697 subdivision 2a

STATE LEVEL INTERAGENCY COORDINATING COMMITTEES (CON'T)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
STATE INTERAGENCY COORDINATING COUNCIL	•The goal of interagency cooperation is to promote the development and implementation of coordinated multi-disciplinary interagency statewide systems for serving young children with disabilities from birth through two years of age, and their families. •Interagency collaboration is necessary at the community and state levels to assure the development of a comprehensive array of educational, health and social services throughout the state. •These services are best provided in a manner which is responsive to the strengths and needs of individual children and their families; sensitive to cultural diversity; and guided by the principle of community based, coordinated, family centered services.	1) Participation on and presentation of significant statewide policy issues to the Governor's Interagency Coordinating Council on Early Childhood Intervention (ICC); 2) allocation of Part H staff and additional resources from each agency including the development of staff assignments and the establishment of priorities through the annual work plan process; 3) coordination of early childhood intervention technical assistance and training to state, regional and local agencies to assist them to meet the standards for this program; 4) development of materials for information dissemination to school districts and local health and human services agencies, as well as community Interagency Early Intervention Committees (IEICs); 5) dissemination of information relating to interagency collaboration and programs to departmental staff; and 6) participation in the development and review of priorities and budget allocations in Minnesota's Plan under Part H.	•the Minnesota Department of Education (MDE) •the Minnesota Department of Health (MDH) •the Minnesota Department of Human Services (DHS)	Young children with disabilities from birth through two years of age and their families as defined by Minnesota Statute, section 120.03 and Minnesota Rule Point 3525.2335.	M.S. section 120.17 and 20 USC 1471 et. seq. (Part H, PL 102-119)

145

146

STATE LEVEL INTERAGENCY COORDINATING COMMITTEES (CON'T)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
STATE INTERAGENCY COORDINATING COUNCIL	Create and ensure a unified, accountable, and comprehensive children's mental health service system.	1) educate each agency about the policies, procedures, funding and services for children with emotional disturbances of all agencies represented; 2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances; 3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children; 4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent; 5) identify mechanisms for better use of federal state funding in the delivery of mental health services for children, and; 6) until February 15, 1992, prepare an annual report on the policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system. This report shall be submitted to the legislature and the state mental health advisory council annually as part of the report required under section 245.487, subdivision 4. The report shall include information from each department represented on: a) the number of children in each department's system who require mental health services; b) the number of children in each system who receive mental health services; c) how mental health services for children are funded within each system; d) how mental health services for children could be coordinated to provide more effectively appropriate mental health services for children; and, e) recommendations for the provision of early screening and identification of mental illness in each system.	The commissioners or designees of commissioners of the departments of human services services, health education, state planning (office of strategic planning), and corrections, and a representative of the Minnesota district judges association juvenile committee, in conjunction with the commissioner of commerce or a designee of the commissioner.	All children ED and SED	M.S. 245.4873 subdivision 2

STATE LEVEL INTERAGENCY COORDINATING COMMITTEES (CON'T)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
STATE TRANSITION INTERAGENCY COMMITTEE	The purpose of the STIC is to facilitate a working relationship between local and state agencies. They will work together to develop a system of services so that all Minnesotans with disabilities have the opportunity to live and work within a community as independently as possible to this end, the STIC has developed this interagency agreement and will provide leadership in its implementation.	1) improve service planning and coordination for individuals; 2) form multidisciplinary interagency planning teams at the school and community levels to facilitate the transition from school to post-secondary education, employment, and community living; and 3) continue ongoing statewide planning and develop policies, standards, practices and funding mechanisms to create an equitable system of community-based transition services.	•Client Assistance Project/Legal Advocacy for Developmentally Disabled Persons in Minnesota •Minnesota Department of Education 1) Secondary Vocational Education Section 2) Special Education Section 3) Interagency Office on Transition Services •Department of Human Services 1) Division for Persons with Developmental Disabilities 2) Mental Health Division •Department of Jobs and Training 1) Division of Rehabilitation Services Vocational Rehabilitation 2) State Services for the Blind 3) State Job Training Office Job Training Partnership Act •Parent Advocacy Coalition for Educational Rights (PACER) •State Board of Vocational Technical Education •State Community College System •State Planning Agency 1) Governor's Planning Council on Developmental Disabilities	Handicapped youth beginning at grade nine or age equivalent.	M.S. 120.17, sub. 16

LOCAL LEVEL INTERAGENCY COORDINATING COMMITTEES

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
LOCAL ADVISORY COUNCIL	The purpose of the LAC is to establish an advisory and advocacy group at the local level on behalf of children with mental health needs.	To let officials at the county level know what services are needed for children and their families.	At least one of the following: • person who was in a mental health program as a child or adolescent • parent of a child with a serious emotional problem • children's mental health professional • representative of minority groups where they exist in significant numbers in a county • representative of the children's mental health local coordinating council(LCC) • family community support services representative	All children ED & SED	245.4875 subdivision 5
LOCAL COORDINATING COUNCIL	County LCC's meet to develop interagency linkages at the community level to provide comprehensive and coordinated services to children with mental health needs.	A. Interagency agreements to coordinate services to children. B. An annual report of the council on the unmet needs of children and their services priorities, and C. An annual report of information collected by the LCC, including: 1) a description of services provided by each of the service systems represented on the council. 2) sources of funding for services and the amounts actually spent. 3) descriptions of the numbers of children and families served during the previous year, and their characteristics, and 4) an estimate of the unmet need of children with emotional disorders in the county.	• Mental Health services • Education services • Correctional services • Law enforcement (where possible) • Vocational services • Social services • Health services • Juvenile court (where possible) • Indian Reservation Authority (if a reservation exists in the county)	All children ED & SED	245.4873 subdivision 3

LOCAL LEVEL INTERAGENCY COORDINATING COMMITTEES (Con't)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
COMMUNITY TRANSITION INTERAGENCY COMMITTEES	A district, group of districts, or special education cooperative, in cooperation with the county or counties in which the district or cooperative is located, shall establish a Community Transition Interagency Committee for handicapped youth, beginning at grade nine or age equivalent, and their families.	1. Identify current services, programs, and funding sources provided within the community for secondary and post-secondary aged handicapped youth and their families. 2. Facilitate the development of multiagency teams to address present and future transition needs of individual students on their individual education plans. 3. Develop a community plan to include a mission, goals and objectives, and an implementation plan to assure that transition needs of handicapped individuals are met. 4. Recommend changes or improvement in the community system of transition services. 5. Exchange information such as appropriate data, effectiveness studies, special projects, exemplary programs and creative funding of programs. 6. Prepare a yearly summary assessing the progress of transition services in the community and disseminate it to all adult service agencies involved in the planning and to the Commissioner of Education by September 1 of each year.	Members of the committee shall consist of representatives from: • special education • vocational and regular education • community education • post-secondary education and training institutions • parents of handicapped youth • local business or industry • rehabilitation services • county social services • health agencies and • additional public or private adult service providers as appropriate.	Handicapped youth, beginning at grade nine or age equivalent.	M.S. 120.17, subdivision 16.

LOCAL LEVEL INTERAGENCY COORDINATING COMMITTEES (Con't)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
CHILD PROTECTION TEAMS	The purpose of the child protection team is to promote comprehensive community programs, which will reduce the occurrence of or prevent reoccurrence of and minimize the negative effect of abuse and neglect of children and their families.	• To encourage and facilitate interagency and inter-disciplinary cooperation and coordination and build trust between those agencies and individuals who provide services to children and their families. • To support the development of community resources in order to provide needed services to families, including obtaining funds for the aforementioned services. • To provide case consultation services for agencies responsible for child protection. • To increase public awareness of the problem of family violence through promoting public education, information and training. • To review proposed legislation and policy and advise or provide comment to government organizations and agencies developing public policy which effects child protection services. • To provide training for team members in order to promote coordination, cooperation, and optimum team function.	The membership of this team shall consist of agencies and individuals who work with, are interested in, or provide services to the abusing and neglecting family.	Abused and neglected children and their families.	M.S. 626.558

LOCAL LEVEL INTERAGENCY COORDINATING COMMITTEES (Con't)

COMMITTEE	MISSION STATEMENT OR PURPOSE	RESPONSIBILITIES	COMMITTEE MEMBERSHIP	TARGET POPULATION	STATUTORY REFERENCES
INTERAGENCY EARLY INTERVENTION COMMITTEES	A district, group of districts, or special education cooperative, in cooperation with the county or counties in which the district or cooperative is located, shall establish an interagency early intervention committee for handicapped children under age five and their families.	The committee shall perform the following ongoing duties: 1) identify current services and funding being provided within the community for handicapped children under the age of five and their families; 2) establish and evaluate the identification, referral, and community learning systems to recommend, where necessary, alterations and improvements; 3) facilitate the development of individual education plans and individual service plans when necessary to appropriately serve handicapped children under the age of five and their families and recommend assignment of financial responsibilities to the appropriate agencies; 4) implement a process for assuring that services involve cooperating agencies at all steps leading to individualized programs; 5) review and comment on the early intervention section of the total special education system for the district and the county social services plan; and 6) facilitate the development of a transitional plan if a service provider is not recommended to continue to provide services. The departments of education, health, and human services are encouraged to provide assistance to the local agencies in developing cooperative plans for providing services.	Members of the committee shall be representatives of local and regional health, education, and county human service agencies; county boards; early childhood family education programs; current service providers; parents of young handicapped children; and other private or public agencies.	Handicapped children under age five and their families.	M.S. 120.17 subdivision 12

157

158